NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council or the Attorney General. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 2. ADMINISTRATION

CHAPTER 5. DEPARTMENT OF ADMINISTRATION PERSONNEL ADMINISTRATION

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R2-5-501	Amend
R2-5-502	Amend
R2-5-503	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 41-763(6) and 41-770

Implementing statutes: A.R.S. §§ 41-783(3), 41-783(17), and 41-783(22)

3. The effective date of the rules:

December 6, 2001

4. A list of all previous notices appearing in the Register addressing the final rule:

Notice of Rulemaking Docket Opening: 7 A.A.R. 2330, June 8, 2001

Notice of Proposed Rulemaking: 7 A.A.R. 2688, June 29, 2001

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Margaret Okolotowicz, Communications and Employee Relations Specialist

Address: 1831 W. Jefferson, Room 106
Phoenix, AZ 85007

Telephone: (602) 542-4459

Fax: (602) 542-2796

6. An explanation of the rule, including the agency's reasons for initiating the rule:

The Standards of Conduct, Hours of Work, and Performance Appraisal System rules are being amended. The rules establish the standards of conduct expected by a state service employee, establish and clarify the hours of work required of a state service employee, and define and clarify the performance appraisal system used to rate the work performance of an employee.

7. A reference to any study that the agency relied on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

None

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

There will be no small business or consumer impact. The impact will be upon employees receiving the benefits of the rules. Any financial impact or administrative expenses should be covered by ordinary operating funds.

10. A description of the changes between the proposed rules, including supplemental notice, and final rules (if applicable):

Two groups, including Human Resources managers and employees representing state agencies, suggested grammatical and other changes relating to clarification. Modifying a word or sentence made these changes. Additionally, grammatical changes were made at the suggestion of Council staff. No substantive changes were made to the submitted rules.

11. A summary of the principle comments and the agency response to them:

Two public hearings were held with only five attendees. There were no oral or written comments offered at these public hearings.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

None

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 2. ADMINISTRATION

CHAPTER 5. DEPARTMENT OF ADMINISTRATION PERSONNEL ADMINISTRATION

ARTICLE 5. CONDITIONS OF EMPLOYMENT

Section
R2-5-501. Standards of Conduct
R2-5-502. Hours of Work
R2-5-503. Performance Appraisal System

ARTICLE 5. CONDITIONS OF EMPLOYMENT

R2-5-501. Standards of Conduct

A. General. In addition to statutorily prohibited conduct, including but not limited to A.R.S. § 41-770, a violation of the standards of conduct listed in subsections (B), (C), and (D) ~~below~~ is cause for discipline or dismissal of a state service employee.

B. Required conduct. A ~~State~~ state ~~Service~~ service ~~employees~~ employee shall at all times:;
1. Maintain high standards of honesty, integrity, and impartiality, free from ~~any~~ personal considerations, favoritism, or partisan demands~~.~~;
2. Be courteous, considerate, and prompt in dealing with and serving the public and other employees~~.~~;
3. Conduct ~~themselves~~ himself or herself in a manner that will not bring discredit or embarrassment to the state~~.~~; and
4. Comply with federal and state laws~~,~~ and rules, and agency policies and directives.

C. Prohibited conduct. A ~~State~~ state ~~Service~~ service ~~employees~~ employee shall not:
1. Use ~~their~~ his or her official position for personal gain, or attempt to use, or use, confidential information for personal advantage~~.~~;
2. Permit ~~themselves~~ himself or herself to be placed under any kind of personal obligation ~~which~~ that could lead ~~any~~ a person to expect official favors~~.~~;
3. Perform ~~any~~ an act in a private capacity ~~which~~ that may be construed to be an official act~~.~~;
4. Accept or solicit, directly or indirectly, anything of economic value as a gift, gratuity, favor, entertainment, or loan ~~which~~ that is, or may appear to be, designed to influence the employee's official conduct. This provision ~~does~~ shall not prohibit acceptance by an employee of food, refreshments, or unsolicited advertising or promotional material of nominal value~~.~~;
5. Directly or indirectly use or allow the use of state equipment or property of any kind, including equipment and property leased to the state, for other than official activities unless authorized by written agency policy or as otherwise allowed by these rules~~.~~;
6. Engage in outside employment or other activity ~~which~~ that is not compatible with the full and proper discharge of the duties and responsibilities of state employment, or ~~which~~ that tends to impair the employee's capacity to perform the employee's duties and responsibilities in an acceptable manner~~.~~; or
7. Inhibit a state employee from joining or refraining from joining an employee organization.

D. Employee rights. An employee shall not take ~~any~~ disciplinary or punitive action against another employee ~~which~~ that impedes or interferes with that employee's exercise of any right granted under the law or these rules. ~~Any~~ An employee or agency representative who is found to have acted in reprisal toward an employee as a result of the exercise of the employee's rights is subject to discipline, ~~as defined in R2-5-801~~ under Title 2, Chapter 5, Article 8. ~~Such~~ The discipline ~~is to~~ shall be administered in accordance with state and federal laws affecting employee rights and benefits.

R2-5-502. Hours of Work

A. State service work week. The state service ~~work-week~~ work week is the period of ~~7~~ seven consecutive days starting Saturday at 12:00 a.m. and ending Friday at 11:59 p.m. An agency head may apply to the Director ~~to grant~~ for an exception from the work week period for all or part of an agency workforce. ~~Exceptions may be granted by the~~ The Director may grant an exception from the work week period to promote efficiency in the state service.

B. Hours of employment.

1. ~~Each~~ An agency head shall determine the hours of employment in the ~~work-week~~ work week for each agency employee.
2. An agency head may provide for breaks during the work period consistent with carrying out the duties of the agency.
3. An agency head may require an employee to work overtime.

C. Flexible work ~~schedules~~ options. ~~If, in an agency head's discretion, it is determined that the agency's existing services can be maintained by employees working a 40-hour work week in a flexible work schedule, the agency head shall offer this option to the affected employees~~. An agency head may offer a flexible 40-hour work week option to an employee if the agency head determines the agency's existing services can be maintained.

D. Attendance standards.

1. An agency head may establish a standard of attendance.
2. Job abandonment. After an absence of three consecutive work days without approval, an agency head may dismiss the employee under R2-5-803 or may separate the employee without prejudice. The agency head shall provide written notice to the employee's last known address.

R2-5-503. Performance Appraisal System

A. General. The Director shall establish a performance appraisal system to evaluate the job performance of ~~all~~ state service employees. An agency head may adopt an alternate employee performance appraisal system, subject to the approval of the Director.

B. Frequency.

1. A supervisor shall evaluate a permanent status employee at least annually.
2. Prior to achieving permanent status, a supervisor shall evaluate a probationary status employee at least twice during the probationary period~~:~~.
   ~~a. At the midpoint of the probationary period, and~~
   ~~b. Thirty days prior to the end of the probationary period.~~
3. An agency head may terminate an original probationary employee at any time with or without a performance evaluation under R2-5-213.

C. Performance rating.

1. The performance appraisal system established by the Director shall contain performance rating levels that distinguish among standard, above standard, and below standard performance. The system shall contain numerical points to apply to each performance rating level established.
2. An agency that adopts an approved alternate employee performance appraisal system shall provide performance rating levels and points appropriate to that system.
3. The Director shall establish a procedure for converting the performance rating levels of an approved alternate employee performance appraisal system to the Arizona Department of Administration rating levels to achieve consistency in human resources actions for which performance levels are a factor.

D. Performance expectations.

1. An employee is expected to meet or exceed performance standards.
2. A supervisor shall comply with performance appraisal requirements.
3. An agency head shall ensure that all performance appraisals are completed as required by this Section.

~~**D.**~~**E.** Review. ~~An employee may file a written request for a review concerning an overall performance rating or a specific performance rating.~~ ~~Each~~ An agency head shall adopt a performance evaluation review procedure subject to the approval of the Director. An employee may file a written request for a review of the employee's overall performance rating or a specific performance rating of the employee.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-101	Amend
R9-22-120	New Section
Article 20	New Article
R9-22-2001	New Section
R9-22-2002	New Section
R9-22-2003	New Section
R9-22-2004	New Section
R9-22-2005	New Section
R9-22-2006	New Section
R9-22-2007	New Section

2. The specific authority for the rulemaking, including both the authorizing statute (general and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2903.01

Implementing statute: A.R.S. § 36-2901.03

3. The effective date of the rules:

December 6, 2001

4. A list of all previous notices appearing in the Register addressing the final rule:

Notice of Rulemaking Docket Opening: 7 A.A.R. 2525, June 15, 2001

Notice of Proposed Rulemaking: 7 A.A.R. 3725, August 31, 2001

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: 801 E. Jefferson
Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:

The rules contain requirements for the Breast and Cervical Cancer Treatment Program that the Arizona Health Care Cost Containment System is required to implement under Laws 2001, Chapter 332 (HB 2194).

7. A reference to any study that the agency relied on in its evaluation of or justification for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

The Arizona State Legislature appropriated $1.3 million in SFY 2001-2002 and $1.4 million in SFY 2002-2003 to AHCCCS from the state general fund for coverage of breast and cervical cancer treatment services to begin January 1, 2002. AHCCCS estimates that approximately 71 women annually (26 women with breast cancer and 45 women with cervical cancer) will be eligible for this program. The direct beneficiaries of the rules will be eligible women who:

• Are screened for breast and cervical cancer through the Well Women Healthcheck Program (WWHP) on or after April 1, 2001;

• Are less than 65 years of age;

• Are ineligible for Title XIX under Title 9, Chapter 22, Articles 14 and 15;

• Receive a positive screen, a confirmed diagnosis by a WWHP physician, and need treatment for breast cancer, cervical cancer, or a pre-cancerous cervical lesion as specified in R9-22-2002;

• Are not covered under creditable coverage as defined in Section 2701(c) of the Public Health Services Act (42 United States Code, Section 300gg(c)); and

• Meet the requirements under R9-22-1416 and R9-22-1418.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

The Administration reorganized the language and reduced the number of Sections from 14 to seven Sections based on comments received from the Governor's Regulatory Review Council. The Administration removed language defining the responsibilities of the WWHP because AHCCCS does not make rules for the WWHP. In addition, the Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the Article. The following chart displays other changes made between proposed and final rules.

#	Proposed Section	Final Section	Response or Change
1.	R9-22-120	R9-22-120	The Administration: • Clarified that "cryotherapy" means the "destruction" rather than "treatment" of abnormal tissue using extremely cold temperature; • Removed language stating that the thin wire used in LEEP "acts as a knife"; and • Added definition of "peer-reviewed".
2.	R9-22-2002	R9-22-2002	The Administration changed "encounter" to "provider visit" in subsections (a), (b), and (c) to add clarity to rule language.
3.	R9-22-2002	R9-22-2002	The Administration removed language stating that adjuvant therapy shall be considered standard of care and not investigational. The Administration also removed language referencing tamoxifen. The reason for removing the language is that a treatment considered as a standard of care is in the rules. The Administration agrees that the standard of care for breast cancer treatment includes tamoxifen; therefore, there is no reason to specifically mention tamoxifen. Further, using the term "standard of care" allows for changes in medical technology. This non-substantive change does not negatively impact political subdivisions, businesses, agencies, private persons or consumers. This change does not impact state revenues for SFY 2001 and 2002.
4.	R9-22-2005	R9-22-2004	The Administration changed the date of application to the date of diagnostic procedure rather than the date WWHP receives a positive diagnosis. This change was made to ensure that an eligible woman's diagnostic procedure is covered by AHCCCS. For example, if eligibility starts from the first day of the month of application and if the date of application is the date that WWHP receives notice of a positive diagnosis, the actual diagnostic procedure may not be covered.
5.	R9-22-2006	R9-22-2004	The Administration added the phrase "including any changes in medical insurance" to clarify that a woman who is applying or who is a member shall provide medical insurance information including any changes in medical insurance.

6.	R9-22-2010	R9-22-2006	The Administration clarified that the effective date of eligibility is the later of: A. The first day of the month in which the WWHP staff receives a positive diagnosis for breast, cervical cancer or a pre-cancerous cervical lesion; B. The first day of the month of Title XIX application; or C. January 1, 2002.

11. A summary of the principal comments and the agency response to them:

On October 2, 2001, the Administration simultaneously conducted public hearings in Phoenix, Yuma, and Sierra Vista. The Phoenix site was linked by videoconference with Tucson and Flagstaff. Prior to the close of record at 5:00 p.m. on October 2, 2001, the agency received no written public comment. The principal comments received by the Administration during the public hearings are listed below.

Rule Citation: R9-22-2002

Comment: American Cancer Society. Why isn't tamoxifen considered a course of treatment? Why is tamoxifen covered for only one year and not five years? How do other states handle tamoxifen?

Response: The Administration removed language stating that adjuvant therapy shall be considered standard of care and not investigational. The Administration also removed language referencing tamoxifen. The reason for removing the language is that a treatment considered as a standard of care is in the rules. The Administration agrees that the standard of care for breast cancer treatment includes tamoxifen; therefore, there is no reason to specifically mention tamoxifen. Further, using the term "standard of care" allows for changes in medical technology. This non-substantive change does not negatively impact political subdivisions, businesses, agencies, private persons or consumers. This change does not impact state revenues for SFY 2001 and 2002.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

No

13. Incorporations by reference and their location in the rules:

Section 2701(c) of the Public Health Services Act (42 United States Code, Section 300gg(c)), January 5, 1999 incorporated at R9-22-2003.

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section
R9-22-101. Location of Definitions
R9-22-120. Breast and Cervical Cancer Treatment Program Related Definitions

ARTICLE 20. BREAST AND CERVICAL CANCER TREATMENT PROGRAM

Section
R9-22-2001. General Requirements
R9-22-2002. Treatment
R9-22-2003. Eligibility Criteria
R9-22-2004. Title XIX Application Process
R9-22-2005. Approval, Denial, or Discontinuance of Eligibility
R9-22-2006. Effective Date of Eligibility
R9-22-2007. Redetermination of Eligibility

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition	Section or Citation
"Accommodation"	R9-22-107
"Act"	R9-22-114
"Active case"	R9-22-109
"Acute mental health services"	R9-22-112
"ADHS"	R9-22-112
"Administration"	A.R.S. § 36-2901
"Administrative law judge"	R9-22-108
"Administrative review"	R9-22-108
"Adverse action"	R9-22-114
"Affiliate corporate organization"	R9-22-106
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-115
"Aggregate"	R9-22-107
"AHCCCS"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-107
"Ambulance"	R9-22-102
"Ancillary department"	R9-22-107
"Annual assessment period"	R9-22-109
"Annual assessment period report"	R9-22-109
"Annual enrollment choice"	R9-22-117
"Appellant"	R9-22-114
"Applicant"	R9-22-101
"Application"	R9-22-101
"Assignment"	R9-22-101
"Authorized representative"	R9-22-114
"Auto-assignment algorithm"	R9-22-117
"Baby Arizona"	R9-22-114
"Behavior management services"	R9-22-112
"Behavioral health evaluation"	R9-22-112
"Behavioral health medical practitioner"	R9-22-112
"Behavioral health professional"	R9-22-112
"Behavioral health service"	R9-22-112
"Behavioral health technician"	R9-22-112
"Behavior management services"	R9-22-112
"BHS"	R9-22-114
"Billed charges"	R9-22-107
"Blind"	R9-22-115
"Board-eligible for psychiatry"	R9-22-112
"Burial plot"	R9-22-114
"Capital costs"	R9-22-107
"Capped fee-for-service"	R9-22-101
"Caretaker relative"	R9-22-114
"Case"	R9-22-109
"Case record"	R9-22-101 and R9-22-109
"Case review"	R9-22-109
"Cash assistance"	R9-22-114
"Categorically-eligible"	R9-22-101
"Certified psychiatric nurse practitioner"	R9-22-112
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-22-112
"CMDP"	R9-22-117
"CMS"	R9-22-101
"Complainant"	R9-22-108
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contractor"	A.R.S. § 36-2901

"Copayment"	R9-22-107
"Corrective action plan"	R9-22-109
"Cost-to-charge ratio"	R9-22-107
"Covered charges"	R9-22-107
"Covered services"	R9-22-102
"CPT"	R9-22-107
"CRS"	R9-22-114
"Cryotherapy"	R9-22-120
"Date of notice"	R9-22-108
"Day"	R9-22-101
"DCSE"	R9-22-114
"De novo hearing"	R9-22-112
"Dentures"	R9-22-102
"Department"	A.R.S. § 36-2901
"Dependent child"	R9-22-114
"DES"	R9-22-101
"Diagnostic services"	R9-22-102
"Director"	R9-22-101
"Disabled"	R9-22-115
"Discussions"	R9-22-106
"Disenrollment"	R9-22-117
"District"	R9-22-109
"DME"	R9-22-102
"DRI inflation factor"	R9-22-107
"E.P.S.D.T. services"	R9-22-102
"Eligible person"	A.R.S. § 36-2901
"Emergency medical condition"	Section 1903(v) of the Social Security Act
"Emergency medical services"	R9-22-102
"Encounter"	R9-22-107
"Enrollment"	R9-22-117
"Enumeration"	R9-22-101
"Equity"	R9-22-101
"Error"	R9-22-109
"FAA"	R9-22-114
"Facility"	R9-22-101
"Factor"	R9-22-101
"FBR"	R9-22-101
"FESP"	R9-22-101
"Finding"	R9-22-109
"First-party liability"	R9-22-110
"Foster care maintenance payment"	41 U.S.C. 675(4)(A)
"FPL"	A.R.S. § 1-215
"FQHC"	R9-22-101
"Grievance"	R9-22-108
"GSA"	R9-22-101
"Health care practitioner"	R9-22-112
"Hearing"	R9-22-108
"Hearing aid"	R9-22-102
"Home health services"	R9-22-102
"Homebound"	R9-22-114
"Hospital"	R9-22-101
"ICU"	R9-22-107
"IHS"	R9-22-117
"IMD"	R9-22-112
"Income"	R9-22-114
"Inmate of a public institution"	42 CFR 435.1009
"Interested party"	R9-22-106
"LEEP"	R9-22-120
"License" or "licensure"	R9-22-101

"Mailing date"	R9-22-114
"Management evaluation review"	R9-22-109
"Medical education costs"	R9-22-107
"Medical expense deduction"	R9-22-114
"Medical record"	R9-22-101
"Medical review"	R9-22-107
"Medical services"	R9-22-101
"Medical supplies"	R9-22-102
"Medical support"	R9-22-114
"Medically necessary"	R9-22-101
"Medicare claim"	R9-22-107
"Medicare HMO"	R9-22-101
"Member"	R9-22-101
"Mental disorder"	R9-22-112
"New hospital"	R9-22-107
"NF"	R9-22-101
"NICU"	R9-22-107
"Noncontracting provider"	A.R.S. § 36-2901
"Nonparent caretaker relative"	R9-22-114
"Notice of Findings"	R9-22-109
"OAH"	R9-22-108
"Occupational therapy"	R9-22-102
"Offeror"	R9-22-106
"Operating costs"	R9-22-107
"Outlier"	R9-22-107
"Outpatient hospital service"	R9-22-107
"Ownership change"	R9-22-107
"Partial Care"	R9-22-112
"Party"	R9-22-108
"Peer group"	R9-22-107
"Peer-reviewed study"	R9-22-120
"Performance measures"	R9-22-109
"Pharmaceutical service"	R9-22-102
"Physical therapy"	R9-22-102
"Physician"	R9-22-102
"Post-stabilization services"	42 CFR 438.114
"Practitioner"	R9-22-102
"Pre-enrollment process"	R9-22-114
"Preponderance of evidence"	R9-22-109
"Prescription"	R9-22-102
"Primary care provider"	R9-22-102
"Primary care provider services"	R9-22-102
"Prior authorization"	R9-22-102
"Private duty nursing services"	R9-22-102
"Proposal"	R9-22-106
"Prospective rates"	R9-22-107
"Prospective rate year"	R9-22-107
"Prudent layperson standard"	42 U.S.C. 1396u-2
"Psychiatrist"	R9-22-112
"Psychologist"	R9-22-112
"Psychosocial rehabilitation services"	R9-22-112
"Qualified ~~Alien~~ alien"	A.R.S. § 36-2903.03
"Quality management"	R9-22-105
"Radiology services"	R9-22-102
"Random sample"	R9-22-109
"RBHA"	R9-22-112
"Rebasing"	R9-22-107
"Referral"	R9-22-101
"Rehabilitation services"	R9-22-102

"Reinsurance"	R9-22-107
"Resources"	R9-22-114
"Respiratory therapy"	R9-22-102
"Respondent"	R9-22-108
"Responsible offeror"	R9-22-106
"Responsive offeror"	R9-22-106
"Review"	R9-22-114
"Review period"	R9-22-109
"RFP"	R9-22-106
"Scope of services"	R9-22-102
"SDAD"	R9-22-107
"Section 1115 Waiver"	A.R.S. § 36-2901
"Service location"	R9-22-101
"Service site"	R9-22-101
"SESP"	R9-22-101
"S.O.B.R.A."	R9-22-101
"Specialist"	R9-22-102
"Specified relative"	R9-22-114
"Speech therapy"	R9-22-102
"Spendthrift restriction"	R9-22-114
"Spouse"	R9-22-101
"SSA"	P.L. 103-296, Title I
"SSI"	R9-22-101
"SSN"	R9-22-101
"Sterilization"	R9-22-102
"Subcontract"	R9-22-101
"Summary report"	R9-22-109
"SVES"	R9-22-114
"Third-party"	R9-22-110
"Third-party liability"	R9-22-110
"Tier"	R9-22-107
"Tiered per diem"	R9-22-107
"Title IV-D"	R9-22-114
"Title IV-E"	R9-22-114
"Title XIX"	42 U.S.C. 1396
"Title XXI"	42 U.S.C. 1397aa
"Tolerance level"	R9-22-109
"Total inpatient hospital days"	R9-22-107
"Utilization management"	R9-22-105
"WWHP"	R9-22-120

B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"Applicant" means a person who submits or whose authorized representative submits, a written, signed, and dated application for AHCCCS benefits.

"Application" means an official request for AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific AHCCCS-covered service and equipment provided to a member. A payment is made in accordance with an upper, or capped, limit established by the Director.

"Case record" means the file and all documents in the file that are used to establish eligibility.

"Categorically-eligible" means a person who is eligible under A.R.S. §§ 36-2901(i), (ii), or (iii) and 36-2934.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means the period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and these rules.

"Day" means a calendar day unless otherwise specified in the text.

"DES" means the Department of Economic Security.

"Director" means the Director of the Administration or the Director's designee.

"Eligible person" means the person defined in A.R.S. § 36-2901.

"Enumeration" means the assignment of a specific nine-digit identification number to a person by the Social Security Administration.

"Equity" means the county assessor full cash or market value of a resource minus valid liens, encumbrances, or both.

"Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution, under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related services.

"Factor" means an organization, a collection agency, a service bureau, or a person who advances money to a provider for accounts receivable that the provider assigns, sells, or otherwise transfers, including transfers through the use of a power of attorney, to the organization, the collection agency, the service bureau, or the person that receives an added fee or a deduction of a portion of the face value of the accounts receivable in return for the advanced money. The term "factor" does not include a business representative, such as a bailing agent or an accounting firm described within these rules, or a health care institution.

"FBR" means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

"FESP" means federal emergency services program covered under R9-22-217 to treat an emergency medical condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

"FQHC" means federally qualified health center.

"GSA" means a geographical service area designated by the Administration within which a contractor of record provides, directly or through a subcontract, a covered health care service to a member enrolled with that contractor of record.

"Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined to meet the requirements of certification.

"Inmate of a public institution" means a person defined by 42 CFR 435.1009.

"License" or "licensure" means a nontransferable authorization that is based on established standards in law, is issued by a state or a county regulatory agency or board, and allows a health care provider to render a health care service lawfully.

"Medical record" means all documents that relate to medical and behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that are kept at the site of the provider.

"Medical services" means health care services provided to a member by a physician, a practitioner, a dentist, or by a health professional and technical personnel under the direction of a physician, a practitioner, or a dentist.

"Medically necessary" means a covered service provided by a physician or other licensed practitioner of the healing arts and within the scope of practice under state law to prevent disease, disability, and other adverse health conditions or their progression; or prolong life.

"Medicare HMO" means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid for participation in the Medicare program under 42 CFR 417(L).

"Member" is defined in A.R.S. § 36-2901.

"NF" means a nursing facility defined in 42 U.S.C. 1396r(a).

"Noncontracting provider" is defined in A.R.S. § 36-2901.

"Referral" means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

"Service location" means any location at which a member obtains any health care service provided by a contractor of record under the terms of a contract.

"Service site" means a location designated by a contractor of record as the location at which a member is to receive health care services.

"SESP" means state emergency services program covered under R9-22-217 to treat an emergency medical condition for a qualified alien or noncitizen who is determined eligible under A.R.S. § 36-2901.06.

"S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

"Spouse" means the husband or wife who has entered into a contract of marriage, recognized as valid by Arizona.

"SSA" means Social Security Administration under P.L. 103-296, Title I.

"SSI" means Supplemental Security Income under Title XVI of the Social Security Act, as amended.

"SSN" means social security number.

"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member;
A marketing organization; or
Any other organization or person who agrees to perform any administrative function or service for a contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

R9-22-120. Breast and Cervical Cancer Treatment Program Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meaning unless the context explicitly requires another meaning:

"Cryotherapy" means the destruction of abnormal tissue using an extremely cold temperature.
"LEEP" means the loop electrosurgical excision procedure that passes an electric current through a thin wire loop.
"Peer-reviewed study" means that, prior to publication, a medical study has been subjected to the review of medical experts who:
Have expertise in the subject matter of the study,
Evaluate the science and methodology of the study,
Are selected by the editorial staff of the publication, and
Review the study without knowledge of the identity or qualifications of the author.
"WWHP" means the Well Women Healthcheck Program administered by the Arizona Department of Health Services.

ARTICLE 20. BREAST AND CERVICAL CANCER TREATMENT PROGRAM

R9-22-2001. General Requirements

A. Confidentiality. The Administration and ADHS shall maintain the confidentiality of a woman's records and shall not disclose a woman's financial, medical, or other confidential information except as allowed under R9-22-512.

B. Covered services. A woman who is eligible under this Article receives all medically necessary services under Articles 2 and 12.

C. Choice of health plan. A woman who is eligible under this Article shall be enrolled with a contractor under Article 17.

R9-22-2002. Treatment

A. Breast cancer. Treatment for breast cancer shall conclude 12 months after the last provider visit for specific treatment for the cancer or at the end of hormonal therapy for the cancer, whichever is later. Treatment includes any of the following:
1. Lumpectomy or surgical removal of breast cancer,
2. Chemotherapy,
3. Radiation therapy, or
4. A treatment that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

B. Pre-cancerous cervical lesion. Treatment for a pre-cancerous cervical lesion, including moderate or severe cervical dysplasia or carcinoma in situ, shall conclude four months after the last provider visit for specific treatment for the pre-cancerous lesion. Treatment includes any of the following:
1. Conization,
2. LEEP,
3. Cryotherapy, or
4. A treatment that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

C. Cervical cancer. Treatment for cervical cancer shall conclude 12 months after the last provider visit for specific treatment for the cancer. Treatment includes any of the following:

1. Surgery,
2. Radiation therapy,
3. Chemotherapy,
4. A treatment that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

R9-22-2003. Eligibility Criteria

A. General. To be eligible for the Breast and Cervical Cancer Treatment Program under this Article, a woman shall meet the requirements of this Article and:
1. Be screened for breast and cervical cancer through the WWHP on or after April 1, 2001;
2. Be less than 65 years of age;
3. Be ineligible for Title XIX under Articles 14 and 15;
4. Receive a positive screen under subsection (A)(1), a confirmed diagnosis by a WWHP physician, and need treatment for breast cancer, cervical cancer, or a pre-cancerous cervical lesion as specified in R9-22-2002;
5. Not be covered under creditable coverage as specified in Section 2701(c) of the Public Health Services Act (42 United States Code, Section 300gg(c)), January 5, 1999, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and
6. Meet the requirements under R9-22-1416 through R9-22-1418.

B. Ineligible woman. A woman is ineligible for Breast and Cervical Cancer Treatment Program under this Article if the woman:
1. Is an inmate of a public institution and federal financial participation (FFP) is not available,
2. Is age 21 through age 64 and resides in an Institution for Mental Disease as defined in R9-22-112, or
3. No longer meets an eligibility requirement under this Article.

C. Metastasized cancer. A woman's eligibility under this Article shall continue if a metastasized cancer is found in another part of the woman's body and that metastasized cancer is a known or presumed complication of the breast or cervical cancer.

D. Reoccurrence of cancer. A woman shall have eligibility reestablished after eligibility under this Article ends if the woman is screened under the WWHP program and additional breast or cervical cancer is found.

E. Ineligible male. A male is precluded from receiving screening and diagnostic services under the WWHP program and is ineligible under this Article.

R9-22-2004. Title XIX Application Process

A. Title XIX application. A woman may apply for eligibility under this Article by submitting a complete Title XIX application as specified in R9-22-1405.

B. Submitting the Title XIX application. The woman may complete and submit a Title XIX application at the time of the WWHP screening or mail the application directly to the Administration.

C. Date of application. The date of the Title XIX application is the date of the diagnostic procedure that results in a positive diagnosis for breast cancer, cervical cancer, or a pre-cancerous cervical lesion.

D. Responsibility of a woman who is applying or who is a member. A woman who is applying or who is a member shall:
1. Give complete and truthful information on the Title XIX application;
2. Comply with the requirements of this Article;
3. Provide medical insurance information including any changes in medical insurance; and
4. Inform the Administration about a change in address, residence, and alienage status.

R9-22-2005. Approval, Denial, or Discontinuance of Eligibility

A. Eligibility determination. The Administration shall determine eligibility under this Article within seven days of receipt of a complete Title XIX application.

B. Approval. If a woman meets all the eligibility requirements in this Article, the Administration shall provide the woman with an approval notice. The approval notice shall contain:
1. The name of the eligible woman,
2. The effective date of eligibility, and
3. Information regarding the woman's appeal and request for hearing rights.

C. Denial. If the Administration denies eligibility, the Administration shall provide the woman with a denial notice. The denial notice shall contain:
1. The name of the ineligible woman,
2. The specific reason why the woman is ineligible,
3. The legal citations supporting the reason for the denial,
4. The location where the woman can review the legal citations, and
5. Information regarding the woman's appeal and request for hearing rights.

D. Discontinuance.

1. Except as specified in subsection (2), if a woman no longer meets an eligibility requirement under this Article, the Administration shall provide the woman an advance Notice of Action no later than 10 days before the effective date of the discontinuance.
2. The Administration may mail the Notice of Action no later than the effective date of the discontinuance if the Administration:
   a. Receives a written statement from the woman voluntarily withdrawing from AHCCCS,
   b. Receives information confirming the death of the woman,
   c. Receives returned mail with no forwarding address from the post office and the woman's whereabouts are unknown, or
   d. Receives information confirming that the woman has been approved for Title XIX services outside the state of Arizona.
3. The Notice of Action shall contain the:
   a. Name of the ineligible woman,
   b. Effective date of the discontinuance,
   c. Specific reason why the woman is discontinued,
   d. Legal citations supporting the reason for the discontinuance,
   e. Location where the woman can review the legal citations, and
   f. Information regarding the woman's appeal and request for hearing rights.

E. Request for hearing. A woman who is approved, denied or discontinued for the Breast and Cervical Cancer Treatment Program may request a hearing under Article 8.

R9-22-2006. Effective Date of Eligibility

The effective date of eligibility is the later of:

1. The first day of the month of a Title XIX application;
2. The first day of the first month the woman meets all the eligibility requirements in this Article; or
3. January 1, 2002.

R9-22-2007. Redetermination of Eligibility

A. Redetermination. Except as provided in subsection (B), the Administration shall complete a redetermination of eligibility at least once a year. If a woman continues to meet the requirements of eligibility for the Breast and Cervical Cancer Treatment Program, the Administration shall notify the woman of continued eligibility for another year. A woman is not required to be screened for breast and cervical cancer through the WWHP under R9-22-2003 at redetermination.

B. Change in circumstance. The Administration shall complete a redetermination of eligibility if there is a change in the woman's circumstances, including a change in treatment under R9-22-2002, that may affect eligibility.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ARIZONA LONG-TERM CARE SYSTEM

PREAMBLE

1. Sections Affected — **Rulemaking Action**

Article 3	Amend
R9-28-301	Amend
R9-28-302	Amend
R9-28-303	Renumber
R9-28-303	New Section
R9-28-304	Renumber
R9-28-304	Amend
R9-28-305	Renumber
R9-28-305	Amend
R9-28-306	Renumber
R9-28-306	Amend
R9-28-307	Renumber
R9-28-307	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2936

Implementing statutes: A.R.S. §§ 36-2936, 36-559, 36-2901, 36-2933(B)

3. The effective date of the rules:

December 7, 2001

4. A list of all previous notices appearing in the Register addressing the final rule:

Notice of Rulemaking Docket Opening: 7 A.A.R. 2526, June 15, 2001

Notice of Proposed Rulemaking: 7 A.A.R. 3436, August 10, 2001

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4534

Fax: (602) 256-6756

6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:

9 A.A.C. 28, Article 3 defines the preadmission screening process (PAS) used by the AHCCCS Administration in determining an applicant or member eligible for receipt of Arizona Long Term Care System (ALTCS) services. R9-28-303 is a new section and expands the current six Sections in the Article to seven Sections. Like concepts have been grouped together to provide additional clarity and conciseness to the rule language.

• *R9-28-301(B)(12), Definitions/EPD* reflects the change under AHCCCS' 1115 waiver with the Centers for Medicaid and Medicare Services (CMS) formerly known as the Health Care Financing Administration (HCFA). Per the waiver agreement, the PAS assessment will be used in lieu of SSA's disability determination. This will expedite those applications for applicants ages 18 through 64.

• *R9-28-303, PAS Process* explains the requirements regarding the PAS assessment process. The Section explains the PAS assessor's role, responsibility, and tasks associated with the administration of the PAS instrument; the role and responsibility of the contracted physician when requested to perform a review of an applicant or a member's PAS assessment; and the circumstances under which the PAS assessment is administered.

• *R9-28-306, Reassessments* reflects the changes in and defines the requirements for when AHCCCS reassessments are conducted.

7. A reference to any study that the agency relied on in its evaluation of or justification for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

The consulting firm of KPMG Peat Marwick was retained by AHCCCS to assist in the development of new PAS instruments for persons who are elderly and physically disabled and persons with developmental disabilities. The Pacific Health Policy Group was retained by KPMG to implement the study and prepare the report. The report was produced in January 1995. It describes in detail the steps followed to create the Arizona DD and EPD PAS and the scoring methodology used for determining eligibility.

The public may review or obtain a copy of the reports, "Development of Pre-Admission Screen for the Elderly and Physically Disabled" and "Development of Pre-Admission Screen for the Developmentally Disabled" through the AHCCCS Administration.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

The economic impact of these provisions is nominal to minimal. The Article complies with the implementation of A.R.S. § 36-2936, which was adopted by AHCCCS to comply with federal law and regulation and the provisions of AHCCCS' 1115 Waiver with the federal government.

The following entities will be impacted by the changes to the rule package:

a. AHCCCS' use of the PAS assessment in lieu of the SSA's disability determination will benefit potential applicants, providers including nursing facilities, health plans, and program contractors. The rationale is as follows:

• Eliminates a duplicative medical evaluation process,

• Reduces application processing time,

• Eliminates costs associated with Social Security disability determination conducted by the Disability Determination Services Administration (DDSA),

• Provides essential services to applicants more expediently, and

• Decreases the amount of time nursing facilities wait for reimbursement by expediting the ALTCS eligibility determination.

b. Members, family members and representatives and AHCCCS will benefit from the change in AHCCCS reassessment timeframes. As noted in R9-28-306, timeframes will be lengthened thereby decreasing the number of AHCCCS reassessments for the members.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

#	Subsection	Response or Change
1.	General	AHCCCS made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules as requested by G.R.R.C. staff.
2.	R9-28-303	AHCCCS changed "An applicant or member with a documented diagnosis of seriously mentally ill" to "An applicant or member who is seriously mentally ill" for clarity in subsection (I).
3.	R9-28-301	AHCCCS reinstated original language defining "formal symbolic substitution" in subsection (C).
4.	R9-28-303	AHCCCS reinstated original language in rule to subsection (I) for clarity and to strengthen the section. An applicant or member who is seriously mentally ill as defined in A.R.S. § 36-550 and achieves a score at or above the threshold specified in R9-28-304, but does not meet the requirements of A.R.S. § 36-2936. Despite a score at or above the threshold, the physician consultant exercises professional judgement and determines that the individual does not meet the requirements of A.R.S. § 36-2936.
5.	R9-28-304	AHCCCS changed language as follows in subsection (B)(3) for clarity. b. The total score is compared to an established threshold ~~score~~. score in R9-28-304. ~~For an~~ Regardless of whether an applicant or member is in Group 1 or in Group 2, the threshold score is 60. Except as defined in R9-28-303, an applicant is determined at immediate risk of institutionalization if one of the following is met: i. The applicant or member has a total score equal to or greater than 60; ii. The applicant or member in Group 1 has a total score less than 60, a functional score equal to or greater than 30 and a medical score equal to or greater than 13; iii. The applicant or member in Group 2 has a total score less than 60 and a functional score equal to or greater than 30 and a weighted score from the orientation section equal to or greater than 5; or iv. The applicant or member in Group 2 has a total score equal to or greater than 30 and is assigned at least two functional points for any one item in the behavior section.
6.	R9-28-304	AHCCCS added the word "respective" prior to "…weight for each scored item" to clarify language in subsection (C).

11. A summary of the principal comments and the agency response to them:

Rule Citation: R9-28-301

Comment: Arizona Consortium for Children with Chronic Illness (ACCCI) - The definition of physically disabled is being changed to exclude the language "the inability to do any substantial gainful activity by reason of any medically determinable physical impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months," in favor of those deemed disabled through SSA or the PAS assessment. Will

this exclude any currently eligible individuals?

Response: CMS has given AHCCCS a waiver to use the PAS assessment in lieu of the DDSA determination indicating that it is comparable. Therefore this will not exclude individuals. This will expedite the entrance of potential applicants into the ALTCS. AHCCCS has changed the definition to read: "Physically disabled" means an applicant or member who is determined physically impaired by AHCCCS through the PAS assessment or DDSA as allowed under AHCCCS's Section 1115 Waiver with CMS."

Rule Citation: R9-28-303

Comment: ACCCI - The initial assessment of a hospitalized applicant is required to be done by a registered nurse assessor, unless one is unavailable. In this event, a social worker assessor is allowed to complete the PAS assessment. This is a change from the old language that required either a registered nurse, or a team consisting of a registered nurse and a social worker to complete the PAS assessment. ACCCI objects to this change. The assessment must be completed by a registered nurse who understands medical terminology, procedures, conditions, and the ramifications of the diagnoses.

Response: AHCCCS explained that this is not a change. A.R.S. § 36-2936(C) allows a social worker to conduct the PAS assessment. The statute gives AHCCCS the authority to prescribe the conditions under which nurses and social workers may perform a PAS assessment.

Social workers also collect information from hospital charts and are able to confer with their peer nurses as well as physicians under contract with AHCCCS.

Rule Citation: PAS instrument

Comment: ACCCI - Assessment of mental retardation in the PAS instrumentation is inconsistent, and inadequate in some age groups. Children, ages birth to two years, are given points for any mental retardation. Children, ages three to five years, are only given points for moderate, severe, or profound mental retardation. Children, ages six to eleven, are not assessed for mental retardation, and children, ages twelve and over, are assessed for moderate, severe, and profound mental retardation. All children should be assessed for any mental retardation and scored proportionate to the severity. This assessment tool has caused children with Down Syndrome, and other diagnoses, that result in mental retardation to not qualify for services.

Response: The consulting firm of KPMG Peat Marwick was retained by AHCCCS to assist in the development of a new PAS instrument. The Pacific Health Policy Group was retained by KPMG to implement the study and prepare the report. The report was produced in January 1995. It describes in detail the steps followed to create the Arizona DD PAS and the scoring methodology used for determining eligibility. AHCCCS will not make a change in the PAS instrument.

The study reflected the following with regard to this issue.

Mental retardation was found to be relevant for children ages six to eleven, but was found to be measuring the same characteristics as a number of other variables (just as "ability to speak" and "clarity of speech" measure virtually the same thing). It was not included in the final PAS instrument for children ages six to eleven, but instead the PAS instrument does include variables such as: "dressing skills," "bladder control," "toileting skills," and "tendency to wander away," all of which capture the same traits as does the "mental retardation" variable. By contrast, for persons age 12 and over, the mental retardation variable was found to do a better job than some of the others tested (such as "bladder control", and so for this group it was retained. This type of differentiation does not suggest a problem, but rather is the very reason the State developed four different PAS instruments. As part of the pilot study, AHCCCS tested eleven year olds using both the "6 - 11"and "12+" instruments and the results were identical. Those who qualified using the "6 - 11" instrument also qualified on the "12+" instrument, and those who did not qualify on the "6 - 11" instrument failed on the "12+" instrument as well.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

Section 1902(e)(9) of SSA, January 1, 1995, in R9-28-303(C)

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 3. PREADMISSION SCREENING (PAS)

Section
R9-28-301. Definitions
R9-28-302. General Provisions
R9-28-303. Preadmission Screening (PAS) Process
~~R9-28-303.~~R9-28-304. Preadmission Screening ~~for Elderly and Physically Disabled Individuals~~ Criteria for an Applicant or Member who is Elderly and Physically Disabled (EPD)
~~R9-28-304.~~R9-28-305. Preadmission Screening ~~for Individuals with Developmental Disabilities~~ Criteria for an Applicant or Member who is Developmentally Disabled (DD)
~~R9-28-305.~~R9-28-306. Reassessments
~~R9-28-306.~~R9-28-307. Transitional Program for ~~Elderly and Physically Disabled and Developmentally Disabled Members and Eligible Persons~~ a Member who is Elderly and Physically Disabled (EPD) or Developmentally Disabled (DD)

ARTICLE 3. PREADMISSION SCREENING (PAS)

R9-28-301. Definitions

A. Common definitions. In addition to definitions contained in A.R.S. Title 36, Chapter 29, and 9 A.A.C. 28, Article 1, the words and phrases in this Chapter have the following meanings for ~~elderly and physically disabled individuals and individuals with developmental disabilities~~ an individual who is elderly or physically disabled (EPD) or developmentally disabled (DD) unless the context explicitly requires another meaning:

~~1.~~ "Acute" means an active medical condition having a sudden onset, lasting a short time, and requiring immediate medical intervention.

"Applicant" is defined in R9-22-101.

"Assessor" means a social worker as defined in this subsection or a licensed registered nurse (RN) who:

Is employed by the Administration to conduct PAS assessments,

Completes a minimum of 30 hours of classroom training in both EPD and DD preadmission screening (PAS) for a total of 60 hours, and

Receives intensive oversight and monitoring by the Administration during the first 30 days of employment with ongoing oversight.

~~2.~~ "Chronic" means a medical condition that is always present, occurs periodically, or is marked by a long duration.

~~3.~~ ~~"Constant/constantly"~~ "Constant or constantly" means at least once a day.

~~4.~~ "Current" means belonging to the present time.

~~5.~~ "Disruptive behavior" means inappropriate behavior including urinating or defecating in inappropriate places, sexual behavior inappropriate to time, place, or person or excessive whining, crying or screaming that interferes with ~~an individual's~~ an applicant's or member's normal activities or the activities of others and requires intervention to stop or interrupt the behavior.

~~6.~~ ~~"Frequent/frequently"~~ "Frequent or Frequently" means weekly to every other day.

~~7.~~ "Functional assessment" means an evaluation of information about an ~~individual's~~ applicant's or member's ability to perform activities related to ~~developmental milestones, activities of daily living, communication, and behaviors.~~ :

Developmental milestones,

Activities of daily living,

Communication, and

Behavior.

~~8.~~ "History" means a medical condition that occurred in the past ~~and may or~~ that may not have required treatment and is not now active.

"Immediate risk of institutionalization" means an applicant or member under A.R.S. § 36-2934(A)(5) and as specified in the Administration's Section 1115 Waiver with CMS.

~~9.~~ "Intervention" means therapeutic treatment, including the use of medication, behavior modification, and physical restraints to control behavior. Intervention may be formal or informal and includes actions taken by ~~friends/family~~ friends or family to control the behavior.

~~10.~~ "Medical assessment" means an evaluation of an ~~individual's~~ applicant's or member's medical condition and the ~~individual's~~ applicant's or member's need for medical services.

~~11.~~ ~~"Medical/nursing~~ "Medical or nursing services and treatments" or "services and treatments" in this Article means specific, ongoing medical, psychiatric, or nursing intervention used actively to resolve or prevent deterioration of a medical condition~~/diagnosis~~. Durable medical equipment and activities of daily living assistive devices are not ~~considered to be~~ treatment unless the equipment or ~~devices are~~ device is used specifically and actively to resolve the existing medical condition.

~~12.~~ ~~"Occasional/occasionally" means less than once per week.~~ "Occasional or occasionally" means from time to time such as less than once per week during the assessment period.

~~13.~~ "Physical participation" means the applicant's or member's active ~~participation, not just being passive or cooperative.~~ participation.

~~14.~~ "Physically lift" means actively bearing some part of an ~~individual's~~ applicant's or member's weight during movement or activity and excludes bracing or guiding activity.

"Physician consultant" means a physician who contracts with the Administration.

~~15.~~ "Social worker" means an individual with two years of case management-related experience or a baccalaureate or master's degree in: ~~social work, rehabilitation, counseling, education, sociology, psychology, or other closely related field, or 2 years of case management related experience.~~

Social work,
Rehabilitation,
Counseling,
Education,
Sociology,
Psychology, or
Other closely related field.

~~16.~~ "Special diet" means a diet planned by a dietitian, nutritionist, or nurse ~~such as~~ that includes high fiber, low sodium, or ~~pureed.~~ pureed food.

~~17.~~ "Toileting" means the process involved in an applicant's or member's managing of the elimination of urine and feces in an appropriate place.

~~18.~~ "Vision" means the ability to perceive objects with ~~one's~~ the eyes.

B. ~~Elderly and physically disabled~~ EPD. In addition to definitions contained in subsection (A), ~~for~~ the following also applies to an applicant or member who is EPD: ~~elderly and physically disabled individuals only:~~

~~1.~~ "Aggression" means physically attacking another, ~~including, but not limited to, throwing objects, punching, biting, pushing, pinching, pulling hair, scratching, and physically threatening behavior.~~ including:

Throwing an object,
Punching,
Biting,
Pushing,
Pinching,
Pulling hair,
Scratching, and
Physically threatening behavior.

~~2.~~ "Bathing" means the process of washing, rinsing, and drying all parts of the body, including an ~~individual's~~ applicant's or member's ability to transfer to a tub or shower and to obtain bath water and equipment.

~~3.~~ "Continence" means the applicant's or member's ability to control the discharge of body waste from bladder or bowel.

~~4.~~ "Dressing" means the physical process of ~~choosing, putting on, securing fasteners, and removing clothing and footwear, including weather appropriate articles but excluding aesthetic concerns such as matching colors. This includes artificial limbs, braces, and other appliances that are needed daily.~~ : choosing, putting on, securing fasteners, and removing clothing and footwear. Dressing includes choosing a weather-appropriate article of clothing but excludes aesthetic concerns. Dressing includes the applicant's or member's ability to put on artificial limbs, braces, and other appliances that are needed daily.

~~5.~~ "Eating" means the process of putting food and fluids by any means into the digestive system.

~~6.~~ "Elderly" means an applicant or member who is age 65 or older.

~~7.~~ "Emotional and cognitive functioning" means an ~~individual's~~ applicant's or member's orientation and mental state, as evidenced by overt ~~behaviors.~~ behavior.

~~8.~~ "EPD" means an applicant or member who is elderly and physically disabled.

~~9.~~ "Grooming" means the applicant's or member's process of tending to ~~one's~~ appearance. ~~This may include, but is not limited to, combing or brushing hair, washing face and hands, shaving, and performing routine nail care, oral hygiene (including denture care), and menstrual care. Grooming does not include aesthetics such as styling hair, skin care, and~~

~~applying make-up.~~ Grooming includes: combing or brushing hair, washing face and hands, shaving, performing routine nail care, oral hygiene (including denture care), and menstrual care. Grooming does not include aesthetics such as styling hair, skin care, and applying cosmetics.

~~10.~~ "Mobility" means the extent of an ~~individual's~~ applicant's or member's purposeful movement within a residential environment.

~~11.~~ "Orientation" means an ~~individual's~~ applicant's or member's awareness of self in relation to person, place, and time.

~~12.~~ "Physically disabled" means ~~the inability to do any substantial gainful activity by reason of any medically determinable physical impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.~~ an applicant or member who is determined physically impaired by the Administration through the PAS assessment as allowed under the Administration's Section 1115 Waiver with CMS.

~~13.~~ "Self-injurious behavior" means repeated self-induced, abusive behavior that is directed toward infliction of immediate physical harm to the body.

~~14.~~ "Sensory" means of or relating to the senses.

~~15.~~ "Suicidal behavior" means an act or intent to take one's life voluntarily.

~~16.~~ "Transferring" means an ~~individual's~~ applicant's or member's ability to move horizontally or vertically between ~~2~~ two surfaces within a residential environment, excluding transfer for toileting or bathing.

~~17.~~ "Wandering" means applicant's or member's moving about with no rational purpose and with a tendency to go beyond the physical ~~parameters~~ parameter of the environment. ~~in a manner that may jeopardize safety.~~

C. ~~Developmentally disabled~~ DD. In addition to definitions contained in subsection (A), the following also applies to an applicant or member ~~for only individuals with developmental disabilities~~ who is DD:

~~1.~~ "Aggression" means physically attacking another, ~~including, but not limited to, throwing objects, punching, biting, pushing, pinching, pulling hair, and scratching.~~ including:

Throwing objects,
Punching,
Biting,
Pushing,
Pinching,
Pulling hair, and
Scratching.

~~2.~~ "Ambulation" means the ability to walk and includes ~~the~~ quality of the walking and the degree of independence in walking.

~~3.~~ "Associating time with ~~events~~ an event and ~~actions"~~ an action" means an ~~individual's~~ applicant's or member's ability to associate a regular ~~events~~ event with a specific time ~~frames.~~ frame.

~~4.~~ "Bathing or showering" means an ~~individual's~~ applicant's or member's ability to complete the bathing process including drawing the bath water, washing, rinsing, and drying all parts of the body, and washing the hair.

~~5.~~ "Caregiver training" means a ~~direct care~~ direct-care staff person or caregiver trained in special health care procedures normally performed or monitored by a licensed professional, such as a registered nurse. These procedures ~~may include, but are not limited to,~~ include ostomy care, positioning for medical necessity, use of an adaptive ~~devices,~~ device or respiratory services such as suctioning or a small volume nebulizer ~~treatments.~~ treatment.

~~6.~~ "Clarity of communication" means an ability to speak in ~~a~~ recognizable language or use a formal symbolic substitution, such as American-Sign Language.

~~7.~~ "Climbing stairs or ~~ramps"~~ a ramp" means an ~~individual's~~ applicant's or member's ability to move up and down stairs or ~~ramps.~~ a ramp.

"Community mobility" means the applicant's or member's ability to move about a neighborhood or community independently, by any mode of transportation.

~~8.~~ "Crawling and standing" means an ~~individual's~~ applicant's or member's ability to crawl and stand with or without support.

"DD" means developmentally disabled.

~~9.~~ "Developmental milestone" means a measure of an ~~individual's~~ applicant's or member's functional abilities including ~~fine and gross motor skills, expressive and receptive language, social and self-help skills, and emotional/affective development.~~ :

Fine and gross motor skills,
Expressive and receptive language,
Social skills,
Self-help skills, and
Emotional or affective development.

~~10. "DD" means developmentally disabled.~~

~~11.~~ "Dressing" means the ability to put on and remove ~~articles~~ an article of clothing and does not include braces nor does it reflect an ~~individual's~~ applicant's or member's ability to match colors or choose clothing appropriate for the weather.
~~12.~~ ~~"Eating/drinking"~~ "Eating or drinking" means the process of putting food and fluid by any means into the digestive system.
~~13.~~ "Expressive verbal communication" means an ~~individual's~~ applicant's or member's ability to communicate thoughts with words or sounds.
~~14.~~ "Food preparation" means the ability to prepare a simple ~~meals.~~ meal including a sandwich, cereal, or a frozen meal.
~~15.~~ "Hand use" means the applicant's or member's ability to use the hands, or hand if an ~~individual~~ applicant or member has only one hand, or has the use of only one hand.
~~16.~~ ~~"Limited/occasional"~~ "Limited or occasional" means a small portion of an entire task or assistance for the task required less than daily.
~~17.~~ "Personal hygiene" means the process of tending to one's appearance. ~~This~~ Personal hygiene may include~~,~~: ~~but is not limited to , combing or brushing hair, washing face and hands, shaving, and performing routine nail care, oral hygiene (including denture care), and menstrual care. Personal hygiene does not include aesthetics such as styling hair, skin care, and applying make-up.~~ combing or brushing hair, washing face and hands, shaving, performing routine nail care, oral hygiene including denture care, and menstrual care. This does not include aesthetics such as styling hair, skin care, and applying cosmetics.
~~18.~~ "Physical interruption" means immediate hands-on interaction to stop a behavior.
~~19.~~ "Remembering ~~instructions~~ an instruction and ~~demonstrations"~~ demonstration" means an ~~individual's~~ applicant's or member's ability to recall ~~instructions~~ an instruction or ~~demonstrations~~ demonstration on how to complete a specific ~~tasks.~~ task.
~~20.~~ ~~"Resistiveness/rebelliousness"~~ "Resistiveness or rebelliousness" means ~~any~~ an applicant's or member's inappropriate, stubborn, or uncooperative behavior ~~excluding~~ . Resistiveness or rebelliousness does not include an applicant's or member's difficulty with processing information or reasonable expression of self-advocacy that includes an applicant's or member's expression of wants and needs.
~~21.~~ "Rolling and sitting" means an ~~individual's~~ applicant's or member's ability to roll and sit independently or with the physical support of another person or with a device such as a pillow or ~~specially designed~~ specially-designed chair.
~~22.~~ "Running or wandering away" means ~~to leave a situation or~~ an applicant or member leaving a physical environment without ~~either~~ notifying or receiving permission from the appropriate individuals ~~as would normally be expected.~~ .
~~23.~~ "Self-injurious behavior" means an ~~individual's~~ applicant's or member's repeated behavior that causes injury to the ~~individual~~ applicant or member. ~~and may include, but is not limited to, biting, scratching, putting inappropriate objects into ear, mouth, or nose, repeatedly picking at skin, and head slapping or banging.~~
~~24.~~ "Verbal or physical threatening" means any behavior in which an ~~individual~~ applicant or member uses words, sounds, or action to threaten harm to self, others, or ~~objects.~~ an object.
~~25.~~ "Wheelchair mobility" means an ~~individual's~~ applicant's or member's mobility using a wheelchair and does not include the ability to transfer to the wheelchair.

R9-28-302. General Provisions

To qualify for services described in A.R.S. § 36-2939:

1. An applicant shall meet the financial criteria described in Article 4, and
2. AHCCCS shall determine that the applicant is at immediate risk of institutionalization under the PAS assessment as specified in this Article.

~~**A.** To qualify for services described in A.R.S. § 36-2939 under the Arizona Long-term Care System (ALTCS), an individual shall meet the criteria described in Article 4 and shall be determined to require care at the level of a nursing facility or an intermediate care facility for the mentally retarded (ICF-MR) in accordance with the preadmission screening (PAS) process described in this Article.~~

~~**B.** An elderly or physically disabled (EPD) individual shall be assessed using the PAS instrument prescribed in R9-28-303 with the exception of physically disabled children less than 6 years of age who shall be assessed using the age-specific PAS instrument prescribed in R9-28-304 and then referred for physician review in accordance with R9-28-302(J). An individual with developmental disabilities shall be assessed using the PAS instrument prescribed in R9-28-304 with the exception of an individual with developmental disabilities residing in a nursing facility who shall be assessed using the PAS instrument prescribed in R9-28-303. An individual with developmental disabilities less than 6 months of age, shall be assessed using the PAS instrument described in R9-28-304, and then referred for physician review in accordance with R9-28-302(J).~~

~~**C.** The PAS instrument shall be completed by an Administration assessor who is a registered nurse or a social worker and who has attended a minimum of 24 hours of classroom training for each type of preadmission screening (for EPD individuals and individuals with developmental disabilities). In addition, the Administration shall provide intensive oversight and mentoring for the assessor during the assessor's first 30 days of employment, and ongoing oversight for the assessor's subsequent period of employment.~~

1. For initial assessments of EPD individuals, the PAS instrument shall be completed by a registered nurse or by a social worker.
2. For initial assessments of individuals with developmental disabilities, the PAS instrument shall be completed by a registered nurse or by a social worker.
3. For initial assessments on hospitalized individuals, the PAS instrument shall be completed by a registered nurse or a team of a registered nurse and social worker.
4. For initial assessments and reassessments of individuals who use a ventilator, the PAS instrument shall be completed by a team composed of a registered nurse and a social worker.

D. Individuals classified as ventilator dependent, as specified in Section 1902 (e)(9) of the Social Security Act, January 1, 1995 (and no future editions), which is incorporated by reference and is on file with the Administration and the Office of the Secretary of State, shall be determined to require care that is provided at a nursing facility or ICF-MR level.

E. Except as provided in subsection (I), an assessor shall conduct the PAS assessment face-to-face with an individual. The assessor shall make reasonable efforts to obtain available medical records. In addition, the assessor may obtain information for the PAS assessment from interviews with the individual, parent, guardian, caregivers, or others familiar with the individual's functional or medical conditions.

F. Except as provided in subsections (L) and (M), the PAS assessment determines an individual's current need for long-term care.

G. Using the information described in subsection (E), and professional judgment, based on education, training, and experience, an assessor shall complete the questions on the PAS instrument.

H. After the PAS instrument is completed, a PAS score is calculated. The calculated PAS score is compared to an established threshold score which is based on statistical analyses of the results of pilot studies completed before implementation of the PAS instrument. Except as provided in subsection (I), the threshold score represents the point at which an individual is determined to require the level of care that is provided at a nursing facility or ICF-MR. The scoring methodology and threshold scores are specified in R9-28-303 and R9-28-304.

I. The Administration shall request that an AHCCCS physician consultant review an individual's file if:

1. An EPD individual's PAS score is less than the threshold specified in R9-28-303, but is not less than 56;
2. The PAS score of an individual with developmental disabilities is less than the threshold specified in R9-28-304, but is not less than 38;
3. Notwithstanding the fact that an individual scores below the threshold, the Administration determines in the course of the preadmission screening that it has reasonable cause to believe that the individual's unique functional abilities or medical condition are such that a physician review is necessary to determine whether the items contained in the scored portions of the PAS instrument would indicate that the individual's condition necessitates the level of care provided in a nursing facility or ICF-MR;
4. An individual has a documented diagnosis as seriously mentally ill as defined in A.R.S. § 36-550, and the Administration determines that the individual has no medical diagnosis that in combination with the serious mental illness could necessitate the level of care provided in a nursing facility or ICF-MR. The review can result in a determination of ineligibility only if the physician determines that despite a score at or above the threshold, the individual does not meet the requirements of A.R.S. § 36-2936; or
5. An individual has a documented diagnosis of Autism, autistic-like behaviors or pervasive developmental disorder, if the individual is not eligible by score.

J. Conducting a review.

1. When conducting a review, the physician shall use the information set out in the PAS instrument to determine whether an individual has a nonpsychiatric medical condition or has a developmental disability that, by itself or in combination with other medical conditions, necessitates the level of care which is provided in a nursing facility or intermediate care facility for the mentally retarded. The physician shall review the PAS instrument and available medical records and use his or her professional judgment to determine whether the individual is at risk of institutionalization. At minimum the physician shall consider the following:
   a. ADL dependence; and delays in development;
   b. Continence;
   c. Orientation;
   d. Behavior;
   e. Medical conditions; stability, prognosis;
   f. Medical nursing treatments including skilled monitoring, medications, therapeutic regimens;
   g. Supervision requirements;
   h. Caregiver skill, training requirements; and
   i. Other factors of significance to the individual case.
2. If the physician is unable to determine eligibility from the PAS instrument and available medical records, the physician may conduct a face-to-face review with the individual or contact others familiar with the individual's needs, including primary care physicians or other caregivers. If the reviewing physician recommends overturning the eligi-

~~bility determination of the initial assessor, the physician shall state the reasons for that decision in the comments section of the instrument.~~

~~**K.** For initial assessments of individuals who are in a hospital or an intensive rehabilitation facility:~~
~~1. If the individual's discharge is planned to occur within 7 days, a PAS assessment shall be performed and medical eligibility determined; or~~
~~2. If the individual's discharge is not planned to occur within 7 days, a PAS assessment shall not be done and the individual shall be denied for ALTCS. Using the age and disability of the individual to determine which is appropriate, the Administration shall:~~
~~a. Determine whether the individual's income is equal to or less than the Supplemental Security Benefit amount in effect and forward the individual's records to the Department of Economic Security for determining AFDC-related acute care eligibility for AHCCCS, or~~
~~b. Evaluate the individual's records for an acute care only determination.~~

~~**L.** Upon request, the Administration shall conduct a PAS assessment to determine whether an individual who has been in a nursing or ICF-MR facility within the 3 months before the month of application, is entitled to receive retroactive benefits for that 3-month period.~~

~~**M.** Upon request, the Administration shall conduct a PAS assessment to determine whether a deceased individual who had been in a nursing facility or ICF-MR during the months covered by the application, would have been eligible to receive ALTCS benefits for those months.~~

R9-28-303. Preadmission Screening (PAS) Process

A. An assessor shall complete the PAS instrument as part of the initial assessment or reassessment for:
1. An applicant or member who is DD or EPD,
2. A hospitalized applicant, or
3. An applicant or member who is ventilator dependent.

B. The assessor shall use the PAS instrument to assess whether the following applicants are at immediate risk of institutionalization:
1. The assessor shall use the PAS instrument prescribed in R9-28-304 to assess an applicant or member who is EPD except a physically disabled applicant or member who is less than six years old.
2. The assessor shall use the age-specific PAS instrument prescribed in R9-28-305 for an applicant or member who is physically disabled or less than 6 years old. After assessing the child in subsection (1), the assessor shall refer the child for physician consultant review under R9-28-303.
3. The assessor shall use the PAS instrument prescribed in R9-28-305 to assess an applicant or member who is DD, except an applicant or member who is:
   a. DD and residing in a NF. The assessor shall use the PAS instrument prescribed in R9-28-304; or
   b. DD or physically disabled and less than six months of age. The assessor shall use the PAS instrument prescribed in R9-28-305. After assessing the child, the assessor shall refer the child for physician consultant review under R9-28-303.

C. For an applicant or member who is ventilator dependent, a registered nurse assessor shall complete the PAS instrument, and determine an applicant or member at immediate risk of institutionalization when the applicant or member is classified as ventilator-dependent, under Section 1902(e)(9) of the Social Security Act, January 1, 1995, incorporated by reference and on file with the Administration and the Office of the Secretary of State, This incorporation by reference contains no future editions or amendments.

D. For an initial assessment of an applicant who is in a hospital or other acute care setting:
1. A registered nurse assessor shall complete the PAS instrument, or
2. In the event that a registered nurse assessor is not available, a social worker assessor shall complete the PAS assessment; and
3. The assessor shall conduct the PAS assessment and determine medical eligibility when discharge is scheduled within seven days.

E. An assessor shall conduct a face-to-face PAS assessment with an applicant or member, except as provided in subsection (H). The assessor shall make reasonable efforts to obtain the applicant's or member's available medical records. The assessor may also obtain information for the PAS assessment from face-to-face interviews with the:
1. Applicant or member,
2. Parent,
3. Guardian,
4. Caregiver, or
5. Any person familiar with the applicant's or member's functional or medical condition.

F. Using the information described in subsection (E), an assessor shall complete the PAS instrument based on education, experience, professional judgment, and training as described in R9-28-301(A).

G. After the assessor completes the PAS instrument, the assessor shall calculate a PAS score. The assessor shall compare the PAS score to an established threshold score. The scoring methodology and threshold scores are specified in R9-28-304

and R9-28-305. Except as determined by physician consultant review as provided in subsections (I) and (J), the threshold score is the point at which an applicant or member is determined at immediate risk of institutionalization.

H. Upon request, the Administration shall conduct a PAS assessment to determine whether a deceased applicant who was in a NF or ICF-MR any time during the months covered by the application would have been eligible to receive ALTCS benefits for those months.

I. The Administration shall request that an AHCCCS physician consultant review the PAS instrument, available medical records, and professional judgement when:

1. The PAS score of an applicant or member who is EPD is less than the threshold specified in R9-28-304, but is at least 56;
2. The PAS score of an applicant or member who is DD is less than the threshold specified in R9-28-305, but is at least 38;
3. An applicant or member scores below the threshold specified in R9-28-304, but the Administration has reasonable cause to believe that the applicant's or member's unique functional abilities or medical condition places the applicant or member at immediate risk of institutionalization;
4. An applicant or member scores below the threshold specified in R9-28-304 and has a documented diagnosis of autism, autistic-like behavior or pervasive developmental disorder; or
5. An applicant or member who is seriously mentally ill as defined in A.R.S. § 36-550 and achieves a score at or above the threshold specified in R9-28-304, but does not meet the requirements of A.R.S. § 36-2936. Despite a score at or above the threshold, the physician consultant exercises professional judgement and determines if the applicant or member meets the requirements of A.R.S. § 36-2936.

J. The physician conducting the review shall use the information contained in the PAS instrument, available medical records, and professional judgement to determine whether an applicant or member is DD or has a nonpsychiatric medical condition that, by itself or in combination with a medical condition, places an applicant or member at immediate risk of institutionalization. At a minimum, the physician shall consider the following:

1. ADL dependence;
2. Delay in development;
3. Continence;
4. Orientation;
5. Behavior;
6. Any medical condition, including stability and prognosis;
7. Any medical nursing treatment including skilled monitoring, medication, and therapeutic regimens;
8. Supervision requirements;
9. Caregiver skill and training requirements; and
10. Any factor of significance to the individual case.

K. The physician shall state the reasons for the recommended decision in the comment section of the PAS instrument.

L. If the physician is unable to determine eligibility from the PAS instrument and available medical records, the physician may conduct a face-to-face review with the applicant or member or contact others familiar with the applicant's or member's needs, including primary care physician or other caregiver.

~~R9-28-303.~~R9-28-304. Preadmission Screening ~~for Elderly or Physically Disabled Individuals~~ Criteria for an Applicant or Member who is Elderly and Physically Disabled (EPD)

A. The PAS instrument for ~~EPD individuals~~ an applicant or member who is EPD includes ~~4~~ four major categories: ~~intake information, functional assessment, emotional and cognitive functioning, and medical assessment.~~

1. Intake information category. The assessor solicits intake information category ~~solicits~~ information on an ~~individual's~~ applicant's or member's demographic background. The components of the intake information category are not included in the calculated PAS score.
2. Functional assessment category. The assessor solicits functional assessment category ~~solicits~~ information on an ~~individual's~~ applicant's or member's:
   a. Need for assistance with activities of daily living, including: ~~bathing, dressing, grooming, eating, mobility, transferring, and toileting in the residential environment or other routine setting;~~
      i. Bathing,
      ii. Dressing,
      iii. Grooming,
      iv. Eating,
      v. Mobility,
      vi. Transferring, and
      vii. Toileting in the residential environment or other routine setting;
   b. Communication and sensory skills, including hearing, expressive communication, and vision; and
   c. Continence, including bowel and bladder functioning. ~~A history of transitory incontinence caused by an acute or temporary condition or illness shall not be considered for rating.~~

3. Emotional and cognitive functioning category. The assessor solicits emotional and cognitive functioning category ~~solicits~~ information on an ~~individual's~~ applicant's or member's:
   a. Orientation to person, place, and time; and
   b. Behavior, including: ~~wandering, self-injurious behavior, aggression, suicidal behavior, and disruptive behavior. Some questions in the behavior section refer to intervention and to medical attention. For the purposes of this subsection, medical attention means an examination by a physician, primary care provider, or both, and treatment if necessary.~~
      i. Wandering,
      ii. Self-injurious behavior,
      iii. Aggression,
      iv. Suicidal behavior, and
      v. Disruptive behavior.
4. Medical assessment category. The assessor solicits medical assessment category ~~solicits~~ information on an ~~individual's~~ applicant's or member's:
   a. Medical ~~conditions~~ condition and the medical condition's impact on the ~~individual's~~ applicant's or member's ability to perform independently activities of daily living ~~independently or whether the conditions require medical or nursing treatments; ~~;
   b. Medical condition that requires medical or nursing service and treatment;
   ~~b.~~c. Medication, treatment, and allergies;
   ~~c.~~d. Specific services and treatments that the ~~individual~~ applicant or member receives or needs and the frequency of ~~those~~ the services and treatments; and
   ~~d.~~e. ~~A description of the individual's physical characteristics~~ Physical measurements, ~~hospital~~ hospitalization history, and ventilator dependency.

B. ~~The PAS instrument for EPD individuals October, 1992, (and no future amendments or editions), is incorporated by reference and is on file with the Administration and the Office of the Secretary of State.~~ The assessor shall use the PAS instrument to assess an applicant or member who is EPD. A copy of the PAS instrument is available from the Administration. ~~When the PAS instrument is completed, the~~ The Administration uses the assessor's PAS instrument responses ~~answers selected by the assessor are used~~ to calculate ~~3~~ three scores: a functional score, a medical score, and a total score.

1. Functional score.
   a. The Administration calculates ~~The~~ the functional score ~~is based on~~ from responses ~~answers~~ to scored ~~questions~~ items in the functional assessment and emotional and cognitive functioning categories. ~~Each answer is assigned~~ For each response to a scored item, a number of points is assigned, ~~a number of points. For each scored question, the number of assigned points~~ which is multiplied by a weighted numerical value~~,~~. The result is ~~resulting in~~ a weighted score for each ~~question~~ response.
   b. ~~For EPD individuals, some questions~~ Designated items in the categories ~~noted below~~ are ~~scored, as indicated in~~ scored according to subsection (C), under the ~~Functional Assessment~~ the following assessment matrices:
      i. Sensory skills;
      ii. Medical conditions; and
      iii. ~~Medical/nursing services~~ Medical or nursing service and ~~treatments.~~ treatment.
   c. ~~For EPD individuals, all questions~~ All items in the following categories ~~noted below~~ are scored, ~~as indicated in~~ according to subsection (C), under the Functional Assessment ~~matrices~~ matrix:
      i. Activities of daily living;
      ii. Continence;
      iii. Orientation; and
      iv. Behavior.
   d. The sum of the weighted scores equals the functional score. The weighted score per ~~question~~ item can range from 0 to 15. The maximum functional score attainable by an ~~individual~~ applicant or member is 141. ~~There is no~~ No minimum functional score ~~that needs to be attained~~ is required except as prescribed in subsections (B)(3)(c) and (B)(3)(d).
2. Medical score.
   a. The EPD population is divided into ~~2~~ two groups for purposes of calculating the medical score. The primary distinction between the ~~2~~ two groups ~~is differences~~ is the difference in medical ~~needs~~ need as follows:
      i. Group 1 includes ~~individuals~~ an applicant or member diagnosed with paralysis, head trauma, multiple sclerosis, amyotrophic lateral sclerosis, or Parkinson's disease that either impacts the ~~individual's~~ applicant's or member's ability to perform activities of daily living independently or requires the applicant or member to receive nursing services or treatments.
      ii. Group 2 includes ~~individuals~~ an applicant or member diagnosed with Alzheimer's disease, dementia, or an organic brain syndrome that either impacts the ~~individual's~~ applicant's or member's ability to perform activities of daily living independently or requires medical or nursing services and treatments. If an ~~individual~~

applicant or member does not meet ~~1~~ one of the criteria for Group 2, the ~~individual~~ applicant or member is considered to be in Group 1.

b. Scoring methodology: Group 1 individuals.
   i. The Administration calculates ~~The~~ the medical score is ~~based on~~ from ~~information obtained from~~ responses to scored items in the medical conditions and the services and treatments sections of the PAS instrument.
   ii. Each response to a scored item in the medical assessment category is assigned a certain number of points, ranging from 0 to 4 points per item.
   iii. The sum of the points equals the medical score, with a maximum score of 63. ~~There is no~~ No minimum medical score ~~that needs to be attained~~ is required, except as prescribed in subsection (B)(3)(c).

c. Scoring Methodology: Group 2 individuals.
   i. The Administration calculates ~~The~~ the medical score ~~is based on~~ ~~information obtained from~~ from responses to scored items in the services and treatments section of the PAS instrument.
   ii. Each response to a scored item in the medical assessment category is assigned a number of points, ranging from 0 to 16 points per item.
   iii. The sum of the points equals the medical score, with a maximum score of 42. ~~There is no~~ No minimum medical score ~~that needs to be attained~~ is required, except as prescribed in subsection (B)(3)(d).

3. Total score.
   a. The sum of an ~~individual's~~ applicant's or member's functional and medical scores equals the total score.
   b. The total score is compared to an established threshold ~~score. For all EPD, regardless~~ score in R9-28-304 calculated under R9-31-304. Regardless of whether ~~the individual is~~ an applicant or member is in Group 1 or in Group 2, the threshold score is 60. ~~Thus, an individual with a total score equal to or greater than 60 is deemed to require care that is provided at the nursing facility or ICF-MR level.~~
   ~~c. If an individual is in Group 1 and has a total score less than 60, a functional score equal to or greater than 30 and a medical score equal to or greater than 13, the is deemed to require care that is provided at the nursing facility or ICF-MR level.~~
   ~~d. If an individual is in Group 2 and has a total score less than 60:~~
      ~~i. A functional score equal to or greater than 30 and a weighted score from the orientation section equal to or greater than 5, the individual is deemed to require care that is provided at the nursing facility or ICF-MR level; or~~
      ~~ii. A functional score equal to or greater than 30 and the individual is assigned at least 2 points for any 1 question in the behavior section, the is deemed to require care that is provided at the nursing facility or ICF-MR level.~~
   c. Except as defined in R9-28-303, an applicant is determined at immediate risk of institutionalization if one of the following is met:
      i. The applicant or member has a total score equal to or greater than 60;
      ii. The applicant or member in Group 1 has a total score less than 60, a functional score equal to or greater than 30, and a medical score equal to or greater than 13;
      iii. The applicant or member in Group 2 has a total score less than 60 and a functional score equal to or greater than 30, and a weighted score from the orientation section equal to or greater than 5; or
      iv. The applicant or member in Group 2 has a total score equal to or greater than 30 and is assigned at least two points for any one item in the behavior section.

C. The following ~~tables~~ matrices represent the number of points available and the respective weight for each scored ~~question~~ item.
1. Functional assessment points. The lowest value in the range of points available per item in the functional assessment category indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.
2. Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, 0, indicates that the applicant or member:
   a. Does not have a medical condition,
   b. Does not need medical or nursing services, or
   c. Does not receive any medical or nursing services.

FUNCTIONAL ASSESSMENT	**# of Points Available Per ~~Question~~ Item 1 (P)**	**Weight (W)**	**Range of Possible Weighted Score per ~~Question~~ Item (P)x(W)**
Activities of Daily Living Section			

Bathing, Dressing, Grooming, Mobility, Toileting	0-5	~~3.00~~ 3	0-15
Eating	0-6	~~2.50~~ 2.5	0-15
Transfer	0-4	3.75	0-15

Continence Section

Bowel	0-2	0	0
	3	.167	.5
Bladder	0-4	~~0.50~~ 0.5	0-2

Sensory Section

	0-1	0	0
Vision	2	1.75	3.5
	3	1.167	3.5

Orientation Section

Person, Place, Time	0-3	~~1.00~~ 1	0-3

~~Emotional/Cognitive~~ Emotional or Cognitive Behavior Section

Aggression, Self-injurious, Suicidal, Wandering	0-3	~~1.00~~ 1	0-3
Disruptive	0-3	~~3.00~~ 3	0-9

~~1The lowest value in the range of points available per question the functional assessment category indicates minimal or no impairment and, conversely, the highest value indicates severe impairment.~~

MEDICAL ASSESSMENT **GROUP 1**	**# of Points Available Per ~~Question~~ Item 1 (P)**	**Weight (W)**	**Range of Possible Weighted Score Per ~~Question~~ Item (P)x(W)**

Medical Conditions Section

~~Paralysis/Sclerosis~~ Paralysis or Sclerosis	0-1	~~3.00~~ 3	0 - 3
~~Alzheimer's/OBS/ Dementia~~ Alzheimer's, or OBS, or Dementia	0-1	~~3.50~~ 3.5	0 - 3.5

Services and Treatments Section

Physical Therapy, Occupational Therapy, Speech Therapy	0-1	~~0.50~~ 0.5	0 - .5
Suctioning, Oxygen, Small Volume Nebulizer, Tracheostomy Care, Postural Drainage, Respiratory Therapy	0-1	~~1.50~~ 1.5	0 or 1.5
Drug Regulation	0-1	~~2.00~~ 2	0 or 2
Decubitus Care, Wound Care, Ostomy Care, Feedings-Tube ~~and/or~~ or Parenteral, Catheter Care, Other Ostomy Care, Dialysis, Fluid ~~Intake/Out put~~ Intake or Output	0-1	~~3.00~~ 3	0 or 3
~~Teaching/Training~~ Teaching or Training Program, ~~Bowel/ Bladder~~ Bowel or Bladder Program, Range of Motion, Other Rehabilitative Nursing, Restraints	0-1	~~4.00~~ 4	0 or 4
MEDICAL ASSESSMENT **GROUP 2**	**# of Points Available per ~~Question~~ Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per ~~Question~~ Item ~~1~~**
Drug Regulation	0-1	~~2.00~~ 2	0 or 2
~~Teaching/Training~~ Teaching or Training Program, ~~Bowel/ Bladder~~ Bowel or Bladder Program, Range of Motion, Other Rehabilitative Nursing	0-1	~~6.00~~ 6	0 or 6
Restraints ~~(Physical/ Chemical)~~ (Physical or Chemical)	0-1	~~16.00~~ 16	0 or 16

~~1~~The lowest value in the range of points available per question item in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.

~~R9-28-304.~~R9-28-305. Preadmission Screening ~~for Individuals with Developmental Disabilities~~ Criteria for an Applicant or Member who is Developmentally Disabled (DD)

A. The Administration shall conduct a PAS assessment of ~~preadmission screening of individuals with developmental disabilities~~ an applicant or member who is DD using ~~1~~ one of ~~4~~ four PAS instruments specifically designed to assess ~~individuals~~ an applicant or member in the following age groups: ~~individuals 12 years of age and older; children 6 to 11 years of age; children 3 to 5 years of age; and children less than 3 years of age.~~

1. 12 years of age and older,
2. Six to 11 years of age,
3. Three to five years of age, and
4. Less than three years of age.

B. The PAS instruments for ~~individuals with developmental disabilities~~ an applicant or member who is DD include ~~3~~ three major categories: ~~intake information, functional assessment, and medical assessment.~~

1. Intake information category. The assessor solicits intake information category ~~solicits~~ information on an ~~individual's~~ applicant's or member's demographic background. ~~No~~ The components of ~~the~~ ~~intake information~~ this category are ~~scored~~ not included in the calculated PAS score.

2. Functional assessment category. The functional assessment category differs by age group~~,~~ as indicated in subsections (B)(2)(a) through (B)(2)(e) ~~below~~:
   a. For ~~individuals~~ an applicant or member 12 years of age and older, the assessor solicits the functional assessment category ~~solicits~~ information on an ~~individual's~~ applicant's or member's:
      i. Need for assistance with independent living skills, including hand use, ambulation, wheelchair mobility, transfer, ~~eating/drinking,~~ eating or drinking, dressing, personal hygiene, bathing or showering, food preparation, community mobility, and toileting;
      ii. Communication skills and cognitive abilities, including expressive verbal communication, clarity of communication, associating time with ~~events~~ an event and ~~actions,~~ action, and remembering ~~instructions~~ an instruction and ~~demonstrations~~ a demonstration; and
      iii. Behavior, including aggression, verbal or physical threatening ~~behavior~~, self-injurious behavior, and ~~resistive/rebellious~~ resistive or rebellious behavior.
   b. For ~~individuals~~ an applicant or member ~~6~~ six through 11 years of age, the assessor solicits the functional assessment category ~~solicits~~ information on an ~~individual's~~ applicant's or member's:
      i. Need for assistance with independent living skills, including rolling and sitting, crawling and standing, ambulation, climbing stairs or ramps, wheelchair mobility, dressing, personal hygiene, bathing or showering, toileting, level of bladder control, and orientation to familiar settings;
      ii. Communication, including expressive verbal communication and clarity of communication; and
      iii. Behavior, including aggression, verbal or physical threatening ~~behavior~~, self-injurious behavior, running or wandering away, and disruptive behavior.
   c. For ~~individuals 3~~ an applicant or member three through ~~5~~ five years of age, the assessor solicits the functional assessment category ~~solicits~~ information on an ~~individual's~~ applicant's or member's:
      i. ~~Status~~ Performance with respect to a series of developmental ~~milestones, including 50 factors~~ milestones that measure an ~~individual's~~ applicant's or member's degree of functional growth;
      ii. Need for assistance with independent living skills, including toileting and dressing, and ~~the individual's~~ an applicant's or member's orientation to familiar settings;
      iii. Communication, including clarity of communication; and
      iv. Behavior, including aggression, verbal or physical threatening ~~behavior~~, and self-injurious behavior.
   d. For ~~individuals 6~~ an applicant or member six months of age ~~and up to~~ ~~3~~ through three years of age, the assessor solicits the functional assessment category ~~solicits~~ information on ~~the individual's degree of functional growth using age specific factors~~ age-specific developmental milestones.
   e. For ~~individuals~~ an applicant or member less than ~~6~~ six months of age, the assessor shall not complete a functional assessment ~~is not completed~~. The assessor shall include a description of the applicant's or member's development in the PAS instrument narrative summary.

~~3. Function assessment scoring.~~
   ~~a. For individuals 12 years of age and older, all questions in the behavior section are scored, and some questions in the independent living skills, communication skills, and cognitive abilities sections are scored, as indicated in subsection (D), under the Functional Assessment matrix.~~
   ~~b. For individuals 6 through 11 years of age, all questions in the communication section are scored, and some questions in the independent living skills and behavior sections are scored, as indicated in subsection (D), under the Functional Assessment matrix.~~
   ~~c. For individuals 3 through 5 years of age, all questions in the developmental milestones and behavior section are scored, and some questions in the independent living skills are scored, as indicated in subsection (D), under the Functional Assessment matrix.~~
   ~~d. For individuals 6 months of age up to 3 years of age, all questions regarding specific factors measuring the degree of functional growth are scored, as indicated in subsection (D), under the Functional Assessment matrix.~~

~~4.~~3. Medical assessment category. The assessor solicits medical assessment category ~~solicits~~ information on an ~~individual's~~ applicant's or member's:
   a. Medical ~~conditions;~~ condition;
   b. Specific services and treatments the ~~individual~~ applicant or member receives or needs and the frequency of those services and treatments;
   c. Current ~~medications; and treatments, medical stability, sensory functioning and physical measurements; and~~ medication;
   d. Medical stability;
   e. Sensory functioning;
   f. Physical measurements; and
   ~~d.~~g. Current placement, ventilator dependency and ~~DD status of the individual, as determined by the Department of Economic Security~~ eligibility for DES Division of Developmental Disabilities program services.

~~5. Medical assessment scoring.~~

~~a. For individuals 12 years of age and older, some questions in the medical conditions section are scored, as indicated in subsection (D), under the Medical Assessment matrix.~~

~~b. For individuals 6 years through 11 years of age, some questions in the medical conditions section are scored, as indicated in subsection (D), under the Medical Assessment matrix.~~

~~c. For individuals 3 years of age up to 6 years of age, some questions in the medical conditions and medical stability sections are scored, as indicated in subsection (D), under the Medical Assessment matrix.~~

~~d. For individuals 6 months of age up to 3 years of age, some questions in the medical conditions, services and treatments, and medical stability sections are scored, as indicated in subsection (D), under the Medical Assessment matrix.~~

~~e. For individuals less than 6 months of age, a medical assessment is completed; however, no questions are scored. These individuals are referred for physician review.~~

C. T~~he PAS instruments for individuals with developmental disabilities August, 1995, (and no future editions or amendments), are incorporated by reference and are on file with the Administration and the Office of the Secretary of State.~~ The assessor shall use the PAS instrument to assess an applicant or member who is DD. A copy of the PAS instrument is available from the Administration. ~~When the PAS instrument is completed, the answers selected by the assessor are used~~ The Administration uses the assessor's PAS instrument responses to calculate ~~3~~ three scores: a functional score, a medical score, and a total score.

1. Functional score.
   a. The Administration calculates ~~The~~ the functional score ~~is based on~~ from responses ~~answers~~ to scored ~~questions~~ items in the functional assessment category. Each ~~answer~~ response is assigned a scored a number of ~~points. For each scored question, the number of points~~ points which is multiplied by a weighted numerical value, resulting in a weighted score for each ~~question~~ response. ~~The weighted numerical values are based on statistical analyses of the results of pilot studies completed before implementation of the PAS instrument and reflect the importance of information on that instrument in predicting whether an individual meets the criteria of A.R.S. § 36-2936.~~
   b. The following items are scored as indicated in subsection (D), under the Functional Assessment matrix:
      i. For an applicant or member 12 years of age and older, all items in the behavior section are scored. Designated items in the independent living skills, communication skills, and cognitive abilities sections are also scored;
      ii. For an applicant or member six through 11 years of age, all items in the communication section are scored. Designated items in the independent living skills and behavior sections are scored;
      iii. For an applicant or member three through five years of age, all items in the developmental milestones and behavior section are scored. Designated items in the independent living skills are scored; and
      iv. For an applicant or member six months of age up to three years of age, all items regarding age specific milestones are scored.
   ~~b.~~c. The sum of the weighted scores equals the functional score. The range of weighted score per ~~question~~ item and maximum functional score for each age group is presented below:

AGE GROUP	RANGE FOR WEIGHTED SCORE PER ~~QUESTION~~ ITEM	MAXIMUM FUNCTIONAL SCORE ATTAINABLE
12+	0 - 11.2	124.1
6-11	0 - ~~24.0~~ 24	112.5
3-5	0 - 15.6	78.2
0-2	0 - 1.4	~~70.0~~ 70

   ~~c.~~d. ~~There is no~~ No minimum functional score ~~that needs to be attained~~ is required.

2. Medical score.
   a. Items (i) through (iii) are scored as indicated in subsection (D), under the Medical Assessment matrix:
      i. The assessor shall score designated items in the medical conditions for an applicant or member 12 years of age and older and six years of age through 11 years of age.
      ii. The assessor shall score designated items in the medical conditions and medical stability sections for an applicant or member three years of age through six years of age.
      iii. The assessor shall score designated items in the medical conditions, services and treatments, and medical stability sections for an applicant or member six months of age through three years of age.
      iv. The assessor shall complete only the medical assessment section of the PAS for an applicant or member less than six months of age. There is no weighted or calculated score assigned. The assessor shall refer the applicant or member for physician consultant review.

~~a.~~b. The Administration calculates ~~The~~ the medical score ~~is based on~~ from information obtained in the medical assessment category. Each response to a scored item is assigned a number of points. The sum of the points equals the medical score. The range of points per item and the maximum medical score attainable by an ~~individual~~ applicant or member is presented below:

AGE GROUP	RANGE OF POINTS PER ITEM	MAXIMUM MEDICAL SCORE ATTAINABLE
12+	0 - 20.6	21.4
6-11	0 - 2.5	~~5.0~~ 5
3-5	0 - 14.8	~~23.0~~ 23
0-2	0 - ~~7.0~~ 7	44.3

~~b.~~c. ~~There is no~~ No minimum medical score ~~that needs to be attained~~ is required.

3. Total score.
   a. The sum of an ~~individual's~~ applicant's or member's functional and medical scores equals the total score.
   b. The total score is compared to an established threshold score in R9-28-304. For ~~all individuals with developmental disabilities~~ an applicant or member who is DD, the threshold score is 40. ~~Thus, an individual~~ Based upon the PAS instrument an applicant or member with a total score equal to or greater than 40 is ~~deemed to require care that is provided at the nursing facility or ICF-MR level~~ at immediate risk of institutionalization.

D. The following ~~tables~~ matrices represent the number of points available and the weight for each scored ~~question~~ item.

1. Functional assessment points. The lowest value in the range of points available per item in the functional assessment category indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.
2. Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, 0, indicates that the applicant or member:
   a. Does not have a medical condition,
   b. Does not need medical or nursing services, or
   c. Does not receive any medical or nursing services.

AGE GROUP 12 AND OLDER FUNCTIONAL ASSESSMENT	**# of Points Available Per ~~Question1~~ Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per ~~Question~~ Item (P) x (W)**
Independent Living Skills Section			
Hand Use, Food Preparation	0-3	~~3.50~~ 3.5	0-10.5
Ambulation, Toileting, Eating, Dressing, Personal Hygiene	0-4	~~2.80~~ 2.8	0-11.2
Communicative Skills and Cognitive Abilities Section			
Associating Time, Remembering Instructions	0-3	~~0.50~~ 0.5	0 - 1.5
Behavior Section			
Aggression, Threatening, Self Injurious	0-4	~~2.80~~ 2.8	0-11.2
Resistive	0-3	~~3.50~~ 3.5	0-10.5

~~[1]The lowest value in the range of points available per question in the functional assessment category indicates minimal to no impairment and, conversely, the highest value indicates severe impairment.~~

AGE GROUP 12 AND OLDER MEDICAL ASSESSMENT	**# of Points Available Per ~~Question1~~ Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per ~~Question~~ Item (P) x (W)**
Medical Conditions Section			
Cerebral Palsy, Epilepsy	0-1	~~0.40~~ 0.4	0-.4
Moderate, Severe, Profound Mental Retardation	0-1	~~20.60~~ 20.6	0-20.6

~~[1]The lowest value in the range of points available per question in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service or treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.~~

AGE GROUP 6-11 FUNCTIONAL ASSESSMENT	**# of Points Available Per ~~Question1~~ Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per ~~Question~~ Item (P) x (W)**
Independent Living Skills Section			
Climbing Stairs, Wheelchair Mobility, Bladder Control	0-3	1.875	0-5.625
Ambulation, Dressing, Bathing, Toileting	0-4	~~1.50~~ 1.5	0-6
~~Crawling/Standing~~ Crawling or Standing	0-5	1.25	0-6.25
~~Rolling/Sitting~~ Rolling or Sitting	0-8	0.833	0-6.66
Communication Section			
Clarity	0-4	~~1.50~~ 1.5	0-6
Expressive Communication	0-5	1.25	0-6.25
Behavior Section			
Wandering	0-4	~~6.00~~ 6	0-24
Disruptive	0-3	~~7.50~~ 7.5	0-22.5

~~[1]The lowest value in the range of points available per question in the functional assessment category indicates minimal to no impairment and, conversely, the highest value indicates severe impairment.~~

AGE GROUP 6 - 11 MEDICAL ASSESSMENT	**# of Points Available Per ~~Question1~~ Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per ~~Question~~ Item (P) x (W)**

Medical Conditions Section			
Cerebral Palsy, Epilepsy	0-1	2.50	0-2.5

~~[1]The lowest value in the range of points available per question in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service or treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.~~

AGE GROUP 3-5 FUNCTIONAL ASSESSMENT	**# of Points Available Per ~~Question1~~ Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per ~~Question~~ Item (P) x (W)**
Developmental Milestones Section			
Factors Measuring an Individual's Degree of Functional Growth	0-1	0.70	0-.7
Independent Living Skills Section			
Toileting, Dressing	0-4	3.90	0-15.6
Behavior Section			
Aggression, Threatening, Self Injurious	0-4	1.00	0-4

~~[1]The lowest value in the range of points available per question in the functional assessment category indicates minimal to no impairment and, conversely, the highest value indicates severe impairment.~~

AGE GROUP 3 - 5 MEDICAL ASSESSMENT	**# of Points Available Per ~~Question1~~ Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per ~~Question~~ Item (P) x (W)**
Medical Conditions Section			
Moderate, Severe, Profound Mental Retardation	0-1	14.80	0-14.8
Medical Stability Section			
Direct Caregiver Required, Special Diet	0-1	4.10	0-4.1

~~[1]The lowest value in the range of points available per question in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service or treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.~~

AGE GROUP 0-2 FUNCTIONAL ASSESSMENT	**# of Points Available Per ~~Question1~~ Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per ~~Question~~ Item (P) x (W)**
Developmental Milestones Section			
Factors Measuring an Individual's Degree of Functional Growth	0-1	1.40	0-1.4

~~[1]The lowest value in the range of points available per question in the functional assessment category indicates minimal to no impairment and, conversely, the highest value indicates severe impairment.~~

AGE GROUP 0-2 MEDICAL ASSESSMENT	**# of Points Available Per ~~Question2~~ Item**	**Weight**	**Range of Possible Weighted Score Per ~~Question~~ Item (P) x (W)**
Services and Treatments Section			
~~Non-Bladder/Bowel~~ Non-Bladder or Bowel Ostomy, Tube Feeding, Oxygen	0-1	6.10	0-6.1
Medical Conditions Section			
Any Mental Retardation, Epilepsy, Cerebral Palsy	0-1	7.00	0-7
Medical Stability Section			
Trained Direct Caregiver, Special Diet or a Minimum of 2 Hospitalizations	0-1	5.00	0-5

~~[2]The lowest value in the range of points available per question in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service or treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.~~

~~R9-28-305.~~R9-28-306. Reassessments

A. An ~~Administration~~ assessor shall reassess each ALTCS member to determine continued ~~need for ALTCS services~~ eligibility. The assessor shall ~~base the determination of~~ determine continued qualification for ALTCS ~~services~~ on the same criteria used for the initial ~~preadmission screening~~ PAS assessment as prescribed in ~~R9-28-302, R9-28-303, and R9-28-304~~ R9-28-303.

B. One or more of the individuals described in ~~R9-28-302(C)~~ R9-28-301 shall conduct each reassessment and may refer the assessment for physician consultant review.

C. ~~Reassessment by the Administration shall occur~~ An assessor shall conduct a reassessment annually except as follows:

1. ~~Annually, except in the following circumstances:~~ An assessor shall reassess a member every four years when:
   a. ~~EPD individuals 80 years of age and older who have been ALTCS eligible for 2 consecutive years shall be reassessed every other year;~~ A member who is EPD, 80 years of age or older, and has been eligible for at least two consecutive years;

b. ~~EPD individuals diagnosed with Alzheimer's disease, dementia, or an organic brain syndrome who have been ALTCS eligible for 2 consecutive years shall be reassessed every other year;~~ A member who is EPD, eligible for ALTCS at least two consecutive years, and is diagnosed with Alzheimer's disease, dementia, or organic brain syndrome;

c. ~~EPD individuals~~ A member who is EPD, ~~who have~~ has been eligible for ~~2~~ two or more consecutive years, and ~~have~~ has had a ~~SNF 2~~ skilled nursing facility-two level of care on ~~their~~ the last ~~2~~ two PAS assessments ~~shall be reassessed every other year~~;

d. ~~EPD individuals who have been eligible for 3 or more consecutive years and have been continuously institutionalized for 3 or more years shall be reassessed every other year;~~ A member who is EPD, has been continuously institutionalized for three or more consecutive years, and has been eligible for ALTCS at least three consecutive years; and

e. ~~DD individuals with severe or profound mental retardation who have been eligible for 2 or more consecutive years shall be reassessed every other year; and~~ A member who is DD, is age 12 or older, and is eligible for two or more consecutive years scoring 90 points or more.

~~f. The Administration identifies other EPD and DD population groups within the ALTCS program for which a reassessment period greater than 1 year is appropriate.~~

2. An assessor shall reassess a member every three years when the member is DD, is age 12 or older, and has been eligible for two or more consecutive years scoring 80 points to less than 90 points;

3. An assessor shall reassess a member every two years when:

a. The member is EPD and has been eligible for two or more consecutive years, has had at least three assessments, and has scored 20 or more points on the last assessment;

b. The member is DD, has severe or profound mental retardation, and has been eligible for two or more consecutive years; and

c. The member is DD, is age 12 or older, eligible for two or more consecutive years, and has scored 61 points to less than 80 points;

4. The Administration identifies another population group within the ALTCS program for which a reassessment period greater than one year is appropriate;

~~2.~~5. In connection with a routine audit of the ~~preadmission screening~~ PAS assessment by the ~~Administration in which~~ Administration an ~~errors~~ error affecting eligibility ~~are~~ is ~~discovered.~~ discovered;

~~3.~~6. In connection with an audit of the ~~preadmission screening~~ PAS assessment requested by a ~~nursing facility~~ NF, program contractor, case manager, or other party ~~where the~~ and Administration ~~has determined~~ determines that continued eligibility is uncertain due to substantial evidence of a change in the member's circumstances or error in the ~~preadmission screening~~ PAS assessment; and

~~4.~~7. At the request of the Administration's physician consultant.

~~R9-28-306.~~R9-28-307. Transitional Program for ~~Elderly and Physically Disabled and Developmentally Disabled Members and Eligible Persons~~ a Member who is Elderly and Physically Disabled (EPD) or Developmentally Disabled (DD)

A. ~~Effective September 1, 1995, a transitional program is established for members and eligible persons meeting the criteria set forth in this Section.~~ The ALTCS transitional program serves members ~~and eligible persons~~ enrolled in the ALTCS program who, at the time of reassessment as described in ~~R9-28-305~~ R9-28-306, ~~are found to~~ no longer meet the threshold specified in ~~R9-28-303~~ R9-28-304 for ~~the elderly and physically disabled~~ EPD or in ~~R9-28-304(B)~~ R9-28-305 for DD. ~~the developmentally disabled. Members and eligible persons qualifying for the transitional program may receive appropriate home- and community-based services.~~ The member must meet all other ALTCS eligibility criteria. The member's PAS assessment will be compared to a second scoring methodology for eligibility in the transitional program as defined in subsections (B) and (C).

B. ~~Developmentally disabled members and eligible persons who are otherwise eligible for ALTCS shall be transferred~~ The Administration shall transfer a member who is DD from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment ~~conducted subsequent to September 1, 1995~~, the total ~~preadmission~~ PAS score is less than the threshold described in ~~R9-28-304(B)~~ R9-28-305 but is ~~not less than~~ at least 30, or the member ~~or eligible person~~ is diagnosed with moderate, severe, or profound mental retardation.

C. ~~Elderly and physically disabled members and eligible persons who are otherwise eligible for ALTCS shall be transferred~~ The Administration shall transfer a member who is EPD from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment ~~conducted subsequent to September 1, 1995~~, the ~~preadmission screening~~ PAS score is less than the threshold described in ~~R9-28-303~~ R9-28-304 but the member ~~or eligible person~~ meets one or more of the following criteria:

1. Has a score of ~~2~~ two or more on ~~3~~ three of the following ~~5~~ activities for daily living: ~~eating, dressing, bathing, toileting, and transferring;~~

a. Eating,

b. Dressing,

c. Bathing,

d. Toileting, and
e. Transferring;

2. Has a diagnosis of: ~~Alzheimer's disease, organic brain syndrome, dementia, Parkinson's disease, or head trauma which impacts activities of daily living;~~
   a. Alzheimer's disease,
   b. Organic brain syndrome,
   c. Dementia,
   d. Parkinson's disease, or
   e. Head trauma that impacts activities of daily living; and
3. Has a score of ~~2~~ two or more on any of the items in the emotional and cognitive functioning category.

D. ~~Members and eligible persons~~ An assessor shall conduct a reassessment annually of a member qualifying for the transitional program ~~shall be reassessed annually~~ to determine if ~~they continue~~ the member continues to meet the criteria specified in subsections (B) and (C).

E. ~~For members and eligible persons~~ For a member residing in a NF or ~~nursing facility (NF) or an intermediate care facility for the mentally retarded (ICF-MR),~~ ICF-MR, the program contractor or the Administration has up to 90 ~~days,~~ continuous days from the ~~effective~~ enrollment date of the member's ~~or eligible person's~~ eligibility for the transitional ~~program,~~ program to move the member ~~or eligible person~~ to an approved home- and community-based setting.

F. ~~Members and eligible persons~~ A member in the transitional program shall continue to receive all medically necessary covered services as specified in Article 2.

G. ~~For members and eligible persons whose condition worsens to the extent that NF or ICF-MR services are medically necessary on a temporary basis, the program contractor or the Administration may place the member or eligible person in a NF or ICF-MR for up to 90 days at any 1 admission.~~ The member is eligible to receive up to 90 continuous days per NF or ICF-MR admission when the member's condition worsens to the extent that an admission is medically necessary.

H. For ~~members~~ a member requiring medically necessary NF or ICF-MR services for longer than 90 days, the program contractor shall request the Administration to conduct a reassessment.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) CHILDREN'S HEALTH INSURANCE PROGRAM

PREAMBLE

1. Sections Affected	Rulemaking Action
R9-31-101	Amend
R9-31-103	Amend
R9-31-211	Amend
R9-31-213	Amend
R9-31-302	Amend
R9-31-303	Amend
R9-31-304	Amend
R9-31-306	Amend
R9-31-307	Amend
R9-31-308	Amend
R9-31-310	Amend
R9-31-504	Amend
R9-31-507	Amend
R9-31-509	Amend
R9-31-511	Amend
R9-31-513	Amend
R9-31-521	Amend
R9-31-1205	Amend
R9-31-1207	Amend
R9-31-1403	Amend
R9-31-1404	Renumber
R9-31-1404	New Section
R9-31-1405	Renumber
R9-31-1405	Amend
R9-31-1406	Renumber

R9-31-1406	Amend
R9-31-1407	Renumber
R9-31-1407	Amend
R9-31-1601	Amend
R9-31-1602	Amend
R9-31-1610	Amend
R9-31-1618	Amend
R9-31-1622	Amend
R9-31-1625	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 36-2982, 36-2986 and 36-2989

Implementing statutes: A.R.S. §§ 36-2982, 36-2983, 36-2988, and 36-2989

3. The effective date of the rules:

December 7, 2001

4. A list of all previous notices appearing in the Register addressing the final rule:

Notice of Rulemaking Docket Opening: 7 A.A.R. 2234, June 1, 2001

Notice of Proposed Rulemaking: 7 A.A.R. 3766, August 31, 2001

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4534

Fax: (602) 256-6756

6. An explanation of the rule, including the agency's reasons for initiating the rule:

The Administration is amending these rules for the Children's Health Insurance Program in order to conform to statutory changes in A.R.S. §§ 36-2982, 36-2983, 36-2988, and 36-2989 (SB 1087 and SB 1577).

7. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

The Administration has amended Articles 1, 2, 3, 5, 12, 14, and 16 to implement the statutory changes from SB 1087 and SB 1577 (A.R.S. §§ 36-2982, 36-2983, and 36-2989). The economic impact of these provisions is nominal to minimal.

AHCCCS may experience an increase in administrative costs due to:

• Determination of eligibility for:

i. Hardship exemption and

ii. Exemption from the three month waiting period of ineligibility due to having had insurance as specified in R9-31-303(M), and

System modifications and ongoing staff resources.

Members, providers, DHS, and the state will benefit from the implementation of SB 1087.

a. Members will benefit due to a change in the service package:

• Multiple eye exams and prescriptive lens,

• Medically necessary non-emergency transportation,

• Unlimited behavioral health inpatient treatment and outpatient visits per year,

• Change in the period of ineligibility due to having had insurance, from six month to three month, as specified in R9-31-303(M), and

• Possibility of hardship exemption.

b. Providers will benefit from a decrease in administrative costs. The same benefit package for Title XIX and XXI will eliminate current tracking processes.

c. Arizona Department of Health Services (ADHS) will have decreased administrative costs due to the deletion of the direct services program.

d. With the removal of the behavioral health limitations, costs are shifted from the General Fund (state monies) to the CHIP Fund (federal monies).

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

#	Subsection	Comment	Change
1.	General	Not applicable	Numerous technical and grammatical changes were made to the proposed rule at the suggestion of G.R.R.C. staff.
2.	R9-31-210	Not Applicable	The Administration excluded this Section because the proposed changes have already been made to R9-31-210 under an exemption from the Administrative Procedure Act.
3.	R9-31-101	*Arizona Consortium for Children with Chronic Illness (ACCCI)*- "An applicant who is seriously or chronically ill under A.R.S. § 36-2983 and R9-31-101" is ambiguous.	Agree and change "An applicant who is seriously ill under R9-31-101 or chronically ill under A.R.S. § 36-2983"
4.	R9-31-503	Not Applicable	The Administration removed this section from the rule package. The Administration will be opening this same section in Chapters 22 and 28 within 90 days and believes that it is best to make similar changes in all three Chapters simultaneously to maintain uniformity.
5.	R9-31-512	Not Applicable	The Administration removed this section from the rule package. The Administration will be opening this same section in Chapters 22 and 28 within 90 days and believes that it is best to make similar changes in all three Chapters simultaneously to maintain uniformity.
6.	R9-31-522	Not Applicable	The Administration removed this section from the rule package. The Administration will be opening this same section in Chapters 22 and 28 within 90 days and believes that it is best to make similar changes in all three Chapters simultaneously to maintain uniformity.
7.	R9-31-1617	Not Applicable	The Administration removed this section from the rule package. The Administration is in the process of reviewing with the intent of filing rules for this topic area in Chapters 22 and 28.

11. A description of the principal comments and the agency response to them.

On October 2, 2001, the Administration simultaneously conducted public hearings in Phoenix, Yuma, and Sierra Vista. The Phoenix site was linked by videoconference with Tucson and Flagstaff. Prior to close of record at 5:00 p.m. on October 2, 2001, the agency received written public comment. The principal oral and written comments received by the Administration during the public hearings are listed below:

Rule Citation: R9-31-101

Comment: Arizona Consortium for Children with Chronic Illness (ACCCI) - The language in statute also states that "the administration shall establish rules to further define conditions that constitute a serious or chronic illness."

"We would like to understand how AHCCCS will apply this (chronic) definition in making the determination of chronic illness in children until the rule further defines these conditions, as required in statute."

Response: Serious illness has been defined in R9-31-101and AHCCCS will utilize the statutory definition of chronic illness.

AHCCCS is addressing the type of a serious or chronic illness via the Universal Application. The Universal Application means the eligibility application used by an AHCCCS applicant or representative who applies for any of the AHCCCS health insurance programs. AHCCCS has added two new sections to its Universal Application to address both areas. If the applicant meets the definition of chronic or serious, the applicant will check the appropriate category. The applicant will identify the condition that meets the requirements of the definition. AHCCCS will further define serious or chronic illness in future rulemaking.

Rule Citation: R9-31-1205(B), R9-31-1205(C)(1), R9-31-1205(C)(2)

Comment: Community Partnership of Southern Arizona (CPSA)-The term "Partial Care Services" no longer exists and should be replaced by "Behavior Health Day Program"; "Behavior Management" should be "Personal Assistance", "Family Support" and "Peer Support"; and Psychosocial Rehabilitation" should be "Living Skills Training" and "Health Promotion". Under the terms of a settlement agreement, Masters Level Specialty Providers may also bill independently.

Response: Partial Care Services, Behavior Management and Psychosocial Rehabilitation are covered services which are listed in the Title XXI State Plan which AHCCCS holds with the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA). These terms are in the AHCCCS-ADHS contract. The terms which CPSA notes are specific services under the broad umbrella terms of behavior management, psychosocial rehabilitation, and partial care. Please see below.

Under the umbrella of Psychosocial Rehabilitation

• health promotion

• living skills training

• pre-job training, education and development

• job coaching and employment support

Under the umbrella of Behavior Management

• behavioral health personal assistance

• family support

• behavioral health peer support

Under the umbrella of Partial Care:

• supervised day program

• therapeutic day program

• medical day program

The issue that Masters Level Specialty Providers may bill independently has been resolved due to conforming changes made to 9 A.A.C. 31 via an exemption from the Administrative Procedure Act which went into effect October 1, 2001. KidsCare recipients are not class members in the settlement agreement mentioned by CPSA.

Rule Citation: R9-31-1406

Comment: William E. Morris Institute for Justice - AHCCCS requires a member pay at least one month's

premiums in order to continue to receive benefits when a grievance or a hearing is requested based upon adverse actions taken by AHCCCS. We strongly oppose this approach to receipt of continuing benefits during an appeal or grievance.

Response: Previously, AHCCCS had required that the member pay three months in advance in order to have coverage during an appeal. The Administration views the change as a positive for the member as the member can pay one month at a time versus three months in advance and monthly thereafter. Under 42 CFR 457.510 and 42 CFR 457.570 the Administration is allowed to continue premiums during an appeal. The Administration does not have the statutory authority to suspend the premiums during an appeal.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

Description	Date	Location
20 CFR 416, Appendix to K	June 6, 1997	R9-31-304
42 CFR 441, Subpart B	January 29, 1985	R9-31-213

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) CHILDREN'S HEALTH INSURANCE PROGRAM

ARTICLE 1. DEFINITIONS

Section
R9-31-101. Location of Definitions
R9-31-103. Eligibility and Enrollment Related Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-31-211. Transportation Services
R9-31-213. Health Risk Assessment and Screening Services

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

Section
R9-31-302. Applications
R9-31-303. Eligibility Criteria
R9-31-304. Income Eligibility
R9-31-306. Enrollment
R9-31-307. Guaranteed Enrollment
R9-31-308. Changes and Redeterminations
R9-31-310. Notice Requirements

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section
R9-31-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions
R9-31-507. Member Record
R9-31-509. Transition and Coordination of Member Care
R9-31-511. Fraud or Abuse
R9-31-513. Discrimination Prohibition
R9-31-521. Program Compliance Audits

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

Section
R9-31-1205. Scope of Behavioral Health Services

R9-31-1207. Standards for Payments

ARTICLE 14. PREMIUMS

Section
R9-31-1403. Administration Requirements for Premium Payment
R9-31-1404. Hardship Exemption
~~R9-31-1404.~~R9-31-1405. Termination for Failure to Pay; Bad Debt
~~R9-31-1405.~~R9-31-1406. Premiums during the Grievance and ~~Appeal~~ Request for Hearing Process
~~R9-31-1406.~~R9-31-1407. Newborns

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

Section
R9-31-1601. General Requirements
R9-31-1602. General Requirements for Scope of Services
R9-31-1610. Transportation Services
R9-31-1618. Claims
R9-31-1622. The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care
R9-31-1625. Behavioral Health Services

ARTICLE 1. DEFINITIONS

R9-31-101. Location of Definitions

~~**A.** For purposes of this Article the term member shall be substituted for the term eligible person.~~

~~**B.**~~**A.** Location of definitions. Definitions applicable to ~~A.A.C. Title 9, Chapter 31~~ 9 A.A.C. 31 are found in the following.

Definition	Section or Citation
"Accommodation"	R9-22-107
"Action"	R9-31-113
"Acute mental health services"	R9-22-112
"ADHS"	R9-31-112
"Administration"	A.R.S. § 36-2901
"Adverse action"	R9-31-108
"Aggregate"	R9-22-107
"AHCCCS"	R9-31-101
"AHCCCS registered provider"	R9-31-101
"Ambulance"	R9-22-102
"Ancillary department"	R9-22-107
"Applicant"	R9-31-101
"Application"	R9-31-101
"Behavior management service"	R9-31-112
"Behavioral health professional"	R9-31-112
"Behavioral health evaluation"	R9-31-112
"Behavioral health medical practitioner"	R9-31-112
"Behavioral health service"	R9-31-112
"Behavioral health technician"	R9-31-112
"Billed charges"	R9-22-107
"Board-eligible for psychiatry"	R9-31-112
"Capital costs"	R9-22-107
"Certified nurse practitioner"	R9-31-102
"Certified psychiatric nurse practitioner"	R9-31-112
"Child"	42 U.S.C. 1397jj
"Chronically ill"	A.R.S. § 36-2983
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-31-112
"CMDP"	R9-31-103
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contractor"	~~R9-31-101~~ A.R.S. § 36-2901
"Contract year"	R9-31-101
"Copayment"	R9-22-107
"Cost avoidance"	R9-31-110
"Cost-to-charge ratio"	R9-22-107

"Covered charges"	R9-31-107
"Covered services"	R9-22-102
"CPT"	R9-22-107
"CRS"	R9-31-103
"Date of action"	R9-31-113
"Day"	R9-22-101
"Denial"	R9-31-113
"De novo hearing"	R9-31-112
"Dentures"	R9-22-102
"DES"	R9-31-103
"Determination"	R9-31-103
"Diagnostic services"	R9-22-102
"Director"	A.R.S. § 36-2981
"DME"	R9-22-102
"DRI inflation factor"	R9-22-107
"Emergency medical condition"	42 U.S.C. 1396b(v)
"Emergency medical services"	R9-22-102
"Encounter"	R9-22-107
"Enrollment"	R9-31-103
"Evaluation"	R9-31-112
"Facility"	R9-22-101
"Factor"	R9-22-101
"First-party liability"	R9-22-110
"FPL"	A.R.S. § 36-2981
"Grievance"	R9-22-108
"Group Health Plan"	42 U.S.C. 1397jj
"GSA"	R9-22-101
"Guardian"	R9-22-103
"Head of Household"	R9-31-103
"Health care practitioner"	R9-31-112
~~"Health plan"~~	~~A.R.S. § 36-2981~~
"Hearing"	R9-22-108
"Hearing aid"	R9-22-102
"Home health services"	R9-22-102
"Household income"	R9-31-103
"Hospital"	R9-31-103
"ICU"	R9-22-107
"IGA"	R9-31-116
"IHS"	R9-31-116
"IHS" or "Tribal Facility Provider"	R9-31-116
"Information"	R9-31-103
"IMD"	R9-31-112
"Inmate of a public institution"	42 CFR 435.1009
"Inpatient hospital services"	R9-31-101
"License" or "licensure"	R9-22-101
"Medical record"	R9-22-101
"Medical review"	R9-31-107
"Medical services"	R9-22-101
"Medical supplies"	R9-22-101
"Member"	A.R.S. § 36-2981
"Mental disorder"	R9-31-112
"Native American"	R9-31-101
"New hospital"	R9-22-107
"NF"	42 U.S.C. 1396r(a)
"NICU"	R9-22-107
"Noncontracting provider"	A.R.S. § 36-2981
"Occupational therapy"	R9-22-102
"Offeror"	R9-31-106
"Operating costs"	R9-22-107

"Outlier"	R9-31-107
"Outpatient hospital service"	R9-22-107
"Ownership change"	R9-22-107
"Partial care"	R9-31-112
"Peer group"	R9-22-107
"Pharmaceutical service"	R9-22-102
"Physical therapy"	R9-22-102
"Physician"	A.R.S. § 36-2981
"Post stabilization services"	42 CFR 438.114
"Practitioner"	R9-22-102
"Pre-existing condition"	R9-31-105
"Prepaid capitated"	A.R.S. § 36-2981
"Prescription"	R9-22-102
"Primary care physician"	A.R.S. § 36-2981
"Primary care practitioner"	A.R.S. § 36-2981
"Primary care provider"	R9-22-102
"Primary care provider services"	R9-22-102
"Prior authorization"	R9-22-102
"Private duty nursing services"	R9-22-102
"Program"	A.R.S. § 36-2981
"Proposal"	R9-31-106
"Prospective rates"	R9-22-107
"Provider"	A.R.S. § 36-2901
"Prudent layperson standard"	42 U.S.C. 1396u-2
"PSP"	R9-31-103
"Psychiatrist"	R9-31-112
"Psychologist"	R9-31-112
"Psychosocial rehabilitation"	R9-31-112
"Qualified alien"	P.L. 104-193
~~"Qualifying Health Center"~~	~~A.R.S. § 36-2981~~
"Qualifying plan"	A.R.S. § 36-2981
"Quality management"	R9-22-105
"Radiology services"	R9-22-102
"RBHA"	R9-31-112
"Rebasing"	R9-22-107
"Redetermination"	R9-31-103
"Referral"	R9-22-101
"Registered nurse"	R9-31-112
"Rehabilitation services"	R9-22-102
"Reinsurance"	R9-22-107
"RFP"	R9-31-106
"Respiratory therapy"	R9-22-102
"Respondent"	R9-22-108
"Scope of services"	R9-22-102
"SDAD"	R9-22-107
"Seriously ill"	R9-31-101
"Service location"	R9-22-101
"Service site"	R9-22-101
"SMI"	A.R.S. § 36-550
"Specialist"	R9-22-102
"Speech therapy"	R9-22-102
"Spouse"	R9-31-103
"SSI-MAO"	R9-31-103
"Sterilization"	R9-22-102
"Subcontract"	R9-22-101
"Subcontractor"	R9-31-101
"Third-party"	R9-22-110
"Third-party liability"	R9-22-110
"Tier"	R9-22-107

"Tiered per diem"	R9-31-107
"Title XIX"	42 U.S.C. 1396
"Title XXI"	42 U.S.C. 1397aa
"TRBHA"	R9-31-116
"Tribal facility"	A.R.S. § 36-2981
"Utilization management"	R9-22-105

~~C.~~**B.** General definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS registered provider" means a provider who:

Has a provider agreement under A.R.S. § 36-2904,

Meets state and federal requirements, and

Is appropriately licensed or certified to provide AHCCCS covered services.

"Applicant" means a person who submits, or ~~on whose behalf is submitted,~~ whose representative submits, a written, signed, and dated application for Title XXI benefits which has not been ~~completed~~ approved or denied.

"Application" means an official request for Title XXI benefits made in accordance with Article 3.

~~"Contractor" means a health plan that contracts with the Administration for the provision of hospitalization and medical care to members under the provisions of this Article or a qualifying plan.~~

"Contract year" means the ~~date~~ period beginning on October 1 and continuing until September 30 of the following year.

"Inpatient hospital services" means medically necessary services that require an inpatient stay in an acute hospital. Inpatient hospital services are provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

"Native American" means Indian as specified in 42 CFR 36.1.

"Seriously ill" means a medical or psychiatric condition manifesting itself by acute symptoms that left untreated may result in:

Death,

Disability,

Disfigurement, or

Dysfunction.

"Subcontractor" means a person, agency or organization who enters into an agreement with a contractor or subcontractor.

R9-31-103. Eligibility and Enrollment Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

~~1.~~ "CMDP" means Comprehensive Medical and Dental Program.

~~2.~~ "CRS" means Children's Rehabilitative Services.

~~3.~~ "DES" means the Department of Economic Security.

~~4.~~ "Determination" means the process by which an applicant is approved or denied for coverage.

~~5.~~ "Enrollment" means the process by which a person is determined eligible for and enrolled in the program.

~~6.~~ "Head of household" means the household member who assumes the responsibility for providing eligibility information for the household unit.

~~7.~~ "Household income" means the total gross amount of all money received by or directly deposited into a financial account of a member of the household income group as defined in R9-31-304.

"Information" means the knowledge received or communicated in written or oral form regarding a circumstance or proof of a circumstance.

~~8.~~ "PSP" means Premium Sharing ~~Project~~ Program, ~~which is a 3-year pilot program~~ established according to A.R.S. § ~~36-2923~~ 36-2923.01.

~~9.~~ "Redetermination" means the periodic review of a member's continued Title XXI eligibility.

~~10.~~ "Spouse" means the husband or wife of a Title XXI applicant or household member, who has entered into a contract of marriage, recognized as valid by Arizona.

~~11.~~ "SSI-MAO" means Supplemental Security Income-Medical Assistance Only.

ARTICLE 2. SCOPE OF SERVICES

R9-31-211. Transportation Services

~~A.~~ ~~Emergency ambulance services.~~

~~1. As specified in A.R.S. § 36-2989, emergency ambulance transportation services shall be a covered service for a member. Payment shall be limited to the cost of transporting the member in a ground or air ambulance:~~

~~a. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs; and~~
~~b. When no other means of transportation is both appropriate and available.~~
~~2. A ground or air ambulance transport that originates in response to a 911 call or other emergency response system shall be reimbursed by the member's contractor if the medical condition at the time of transport justified a medically necessary ambulance transport. No prior authorization is required for reimbursement of these transports.~~
~~3. Determination of whether transport is medically necessary shall be based upon the medical condition of the member at the time of transport.~~
~~4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure to notify the contractor may constitute cause for denial of claims.~~
~~**B.** Air ambulance services shall be covered only if:~~
~~1. The air ambulance transport is initiated upon the request of an emergency response unit, a law enforcement official, a hospital or clinic medical staff member, a physician, or a practitioner;~~
~~2. The point of pickup is inaccessible by ground ambulance, or great distances, or other obstacles are involved in getting emergency services to the member or transporting the member to the nearest hospital or other provider with appropriate facilities; and~~
~~3. The medical condition of the member requires timely ambulance service and ground ambulance service will not suffice.~~
~~**C.** Medically necessary patient transfers provided by an emergency air or ground transportation provider may be covered when a member receiving inpatient services requires transport to another level of care or requires round trip transport to another facility to obtain necessary specialized diagnostic treatment services if:~~
~~1. A member's condition is such that the use of any other method of transportation would be harmful to a member's health, and~~
~~2. Services are not available in the facility where a member is a patient.~~
~~**D.** Meals, lodging and escort services.~~
~~1. Expenses for meals and lodging for a member while en route to, or returning from, an approved and prior authorized health care service site out of a member's service area or county of residence shall be a Title XXI covered service.~~
~~2. Expenses of an escort, who may be a family household member accompanying a member out of a member's service area shall be covered if the services of the escort are ordered in writing by a member's primary care provider, attending physician or practitioner.~~
~~**E.** Limitations.~~
~~1. Expenses shall be allowed only when a member requires a covered service that is not available in the service area;~~
~~2. If a member is admitted to an inpatient facility, expenses for the escort shall be covered only when accompanying a member en route to, and returning from, the inpatient facility; and~~
~~3. A salary for an escort shall be covered if an escort is not a part of a member's family household.~~
~~**F.** Non-emergency transportation services are not covered as specified in A.R.S. § 36-2989.~~
The Administration shall provide transportation services under A.A.C. R9-22-211.

R9-31-213. Health Risk Assessment and Screening Services

A. As ~~specified in~~ authorized by A.R.S. § 36-2989, the following services shall be covered for a member~~less than 19 years of age~~:
1. Screening services, including:
   a. Comprehensive health, behavioral health and developmental histories;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history; and
   d. Health education, including anticipatory guidance.
2. Vision services ~~as specified in A.R.S. § 36-2989~~ including:
   a. ~~Treatment for medical conditions of the eye~~ Diagnosis and treatment for defects in vision,
   b. ~~One eye examination per contract year, and~~ Eye examinations for the provision of prescriptive lenses, and
   c. Provision of ~~1 pair of~~ prescriptive lenses ~~per contract year~~.
3. Hearing services, including:
   a. Diagnosis and treatment for defects in hearing~~;~~ ,
   b. Testing to determine hearing impairment~~;~~ , and
   c. Provision of hearing aids.

B. All providers of services shall meet the following standards:
1. Provide services by or under the direction of, the member's primary care provider or dentist.
2. Perform tests and examinations as specified in contract and ~~in accordance with the AHCCCS Administration Periodicity Schedule.~~ under 42 CFR 441Subpart B, January 29, 1985, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments.

3. ~~a.~~ Refer members as necessary for dental diagnosis and treatment, and necessary specialty care.
4. ~~b.~~ Refer members as necessary for behavioral health evaluation and treatment services as specified in 9 A.A.C. 31, Article 12.

C. ~~Contractors~~ A contractor shall meet the following additional conditions for members:
1. Provide information to members and their parents or guardians concerning services; and
2. Notify members and their parents or guardians regarding the initiation of screening and subsequent appointments according to the AHCCCS Administration Periodicity Schedule.

D. ~~Members with special health care needs shall be referred to the Children's Rehabilitative Service program.~~ A contractor, primary care provider, attending physician, or practitioner shall refer a member with special health care needs under A.A.C. R9-7-301 to CRS.

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-31-302. Applications

A. Availability. The Administration shall make available ~~Title XXI~~ program applications. Any person may request ~~a Title XXI~~ a program application.

B. Submission of ~~Applications~~ applications. An application ~~shall be~~ is completed and submitted to the Administration:
1. In person,
2. By mail,
3. By fax, or
4. By other form approved by the Administration.

C. Date of application. The date of application is the date the Administration or its designee receives an application ~~which~~ that:
1. Is signed by the person making ~~an~~ the application,
2. Includes the name of the person for whom assistance is requested, and
3. Includes the address and telephone number of the person submitting the application.

D. Completed application.
1. The Administration shall consider an application complete when:
   a. All questions are answered,
   b. An enrollment choice is included, and
   c. All necessary verification is provided by an applicant or an applicant's representative.
2. ~~When~~ If the application is incomplete, the Administration shall do one or both of the following:
   a. Contact an applicant or an applicant's representative by telephone to obtain the missing information required for an eligibility determination; ~~or~~
   b. Mail a ~~pending notice~~ request for additional information to an applicant or an applicant's representative, allowing 10 days from the date of the ~~notice~~ request to provide the required additional information ~~listed on the pending notice~~.

E. Eligibility determination processing time.
1. ~~Except when there is an emergency beyond the Administration's control~~ When an application is complete, the Administration shall ~~not delay~~ mail the notification to the applicant regarding the eligibility determination ~~beyond~~ no more than 30 days from the date of application except when there is an emergency beyond the Administration's control. ~~when information and verification necessary to make the determination has been provided and obtained.~~
2. An applicant shall provide the Administration with all requested ~~verification~~ information within 10 days from the ~~notice~~ date of the written request for the information. If an applicant fails to provide the requested information and fails to request an extension of the 10 day period or the request for extension is denied, the Administration ~~may~~ shall deny eligibility.

F. Waiting list. If the Administration stops processing an application because the monies are insufficient as specified in R9-31-301(C)(1), the Administration shall place an applicant on a waiting list and notify the applicant. When ~~increased~~ sufficient funding becomes available, the Administration shall contact an applicant on the waiting list and ask the applicant to submit a new application if the original application is more than 60 days old. Spaces shall be filled as a completed application is received and approved.

R9-31-303. Eligibility Criteria

Eligibility. To be eligible for the program, ~~a person~~ an applicant shall meet all the following eligibility requirements:
1. Age. Is under 19 years of age. A child's coverage shall continue through the month in which a child turns age 19 if the child is otherwise eligible;
2. Citizenship. Is a United States citizen or a qualified alien ~~as specified in~~ under A.R.S. § 36-2983;
3. Residency. Is a resident of the state of Arizona ~~as specified in~~ under A.R.S. § 36-2983. An Arizona resident is a person who currently lives in Arizona and intends to remain in Arizona indefinitely;
4. Income. Meets the income requirements in R9-31-304;
5. Cost sharing. Pays the cost sharing premium amount when premiums are required as specified in A.R.S. § 36-2982;

6. Social security number. ~~Provides a social security number or applies for one within 30 days after an applicant submits a Title XXI application as specified in A.R.S. § 36-2983.~~ The Administration shall not deny eligibility for Title XXI if an applicant does not provide or apply for a social security number except as specified under A.R.S. § 36-2983.~~unless the sole reason the child is ineligible for Title XIX is for failure to comply with social security number requirements specified in 42 CFR 435.910 and 42 CFR 435.920 as of May 29~~ February 28, ~~1986, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments;~~
7. Assignment. Assigns rights to any ~~1st- or 3rd-party~~ first- or third- party coverage of medical care as specified in 9 A.A.C. 31, Article 10;
8. Other federal program. Is not eligible for Title XIX or other federally operated or financed health care insurance program, except the Indian Health Service ~~or a Tribal Facility~~ as specified in A.R.S. § 36-2983;
9. Inmate of a public institution. Is not an inmate of a public institution, as specified in A.R.S. § 36-2983;
10. Patient in an institution for mental disease. Is not a patient in an institution for mental disease at the time of application, or at the time of redetermination, as specified in A.R.S. § 36-2983;
11. Other health coverage. Is not covered under:
    a. An employer's group health insurance plan,
    b. Family or individual health insurance, or
    c. Other health insurance;
12. State health benefits. Is not a member of a family that is eligible for health benefits coverage under a state health benefit plan based on ~~an applicant, a member, or a parent's~~ a family member's employment with a public agency in the state of Arizona;
13. Prior health insurance coverage. Has not been covered by health insurance during the previous ~~6~~ three months unless that health insurance was discontinued due to the involuntary loss of employment or other involuntary reason as specified in A.R.S. § 36-2983. The ~~6~~ three months of ineligibility due to previous insurance coverage shall not apply to:
    a. A newborn as defined in R9-31-309;
    b. A Title XIX member as specified in 9 A.A.C. 22, Article 1;
    ~~c. An MI/MN member as specified in 9 A.A.C. 22, Article 1;~~
    ~~d. An EAC member as specified in 9 A.A.C. 22, Article 1;~~
    ~~e. An ELIC member as specified in 9 A.A.C. 22, Article 1;~~
    ~~f. A state funded SSI-MAO non-qualified alien as specified in A.R.S. § 36-2903.03;~~
    c. An applicant who is seriously ill under R9-31-101 or chronically ill under A.R.S. § 36-2983;
    ~~g.~~d. A Title XXI member who loses insurance coverage;
    ~~h.~~e. A CRS member; or
    ~~i.~~f. A Native American member receiving services from IHS or a Tribal Facility.

R9-31-304. Income Eligibility

A. Income standard. The combined gross income of the household income group members as specified in subsection (C) shall not exceed the percentage of the appropriate FPL for the Title XXI household income group size as specified in A.R.S. § 36-2981 ~~for the state fiscal year~~.

B. Countable income. The Administration shall count all income received during a month by the household income group members as specified in subsection (C) except income ~~which~~ that is specified in subsections (D) and (E).

C. Title XXI household income group.
1. For this Section:
    a. "Child" means a person under 19 years of age or an unborn child.
    b. "Parent" means a biological, adoptive, or step parent.
2. The following related persons, when residing together, constitute a Title XXI household income group:
    a. A married couple and children of either one or both;
    b. An unmarried couple with a common child and other ~~children~~ child of either 1 or both;
    c. A married couple when one or both are under age 19 with no ~~children~~ child;
    d. A single parent and the single parent's ~~children~~ child;
    e. A child who does not live with a parent; and
    f. The following persons, when living with a child:
        i. A spouse of the child;
        ii. A child of the spouse child;
        iii. A child of the child; and
        iv. The other parent of a child of the child.
3. A person who is absent from a household shall be included in the child's household income group if absent:
    a. For 30 days or less,
    b. For the purpose of seeking employment or to maintain a job,
    c. For serving in the military, or

d. For an educational purpose and the child's parent claims the child as a dependent on the parent's income tax return.

D. Income disregards. When determining gross income of the household, the Administration shall disregard the following:
1. Income specified in 20 CFR ~~Part~~ 416. Appendix to subpart K as of ~~April 1, 1997~~ June 6, 1997, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments;
2. Income paid according to federal law that prohibits the use of the income when determining eligibility for public benefits;
3. Money received ~~by a member~~ as the result of the conversion of an asset;
4. Income tax refunds; and
5. For a ~~self-employed household member~~ income, the Administration shall count only the net income of that self-employment, after deducting the expenses of producing that income, but not deducting income taxes or capital investments.

E. Regular infrequent income. Income that is received regularly but less often than monthly shall be pro-rated over the number of months between payments. ~~with only the pro-rated monthly amount.~~

R9-31-306. Enrollment

A. Selection choices.
1. Except as provided in subsections (A)(3), (4), and (5), at the time of application, an applicant shall select from the following enrollment choices:
   a. A contractor which includes a ~~health plan~~ contractor or a qualifying plan as defined in A.R.S. § 36-2981, or
   ~~b. A qualifying health center as specified in A.R.S. § 36-2907.06, or~~
   ~~c.~~b. The IHS as specified in A.R.S. § 36-2982. If a member is enrolled with the IHS, a member may elect to receive covered services from a participating ~~638~~ Tribal Facility.
2. Except as provided in subsections (A)(3), (4), and (5), coverage shall not begin until a Title XXI enrollment choice is made.
3. The Administration shall enroll a member with CMDP when a member is a foster care child according to A.R.S. § 8-512.
4. When a Title XIX member becomes ineligible for Title XIX and DES determines ~~a child~~ the member eligible for Title XXI with no break in coverage,
   a. The Title XXI ~~child~~ member shall remain enrolled with the Title XIX contractor; and
   b. The Administration shall send the Title XXI member a notice explaining the member's right to choose as specified in subsection (A)(1).
5. When ~~a person~~ an applicant applies for Title XIX through DES and DES determines ~~a child~~ the applicant ineligible for Title XIX but eligible for Title XXI, the Administration shall enroll the ~~child~~ applicant for Title XXI as follows:
   a. If a Title XIX ~~health plan~~ contractor pre-enrollment choice is pending at the time the Administration receives the Title XXI approval from DES, the Administration may:
      i. Enroll ~~a child~~ member with the Title XIX ~~health plan~~ contractor, and
      ii. Notify the member of the member's enrollment and provide the member an opportunity to select an enrollment choice as specified in subsection (A)(1).
   b. If there is no pending Title XIX choice at the time the Administration receives the Title XXI approval from DES, the Administration shall pend the Title XXI decision and obtain a choice from the member as specified in subsection (A)(1).

B. Effective date of initial enrollment.
1. For an eligibility ~~determinations~~ determination completed by the 25th day of the month, enrollment shall begin on the first day of the month following the determination of eligibility.
2. For an eligibility determination completed after the 25th day of the month, enrollment shall begin on the first day of the second month following the determination of eligibility.

C. Enrollment changes.
1. If a member moves from ~~1~~ one GSA to another GSA during the period of enrollment, enrollment changes shall occur as follows:
   a. If a member's current enrollment choice is available in a member's new GSA, a member shall remain enrolled with the member's current enrollment choice.
   b. If a member's current enrollment choice is not available in the new GSA, a member shall:
      i. Remain enrolled with the current enrollment choice. The current enrollment choice may limit services to emergency services outside the GSA as specified in R9-31-201.
      ii. Select from the enrollment choices provided in R9-31-306(A)(1) that are available in the new GSA. Once a new choice is made, a member shall be enrolled with the new choice effective with the date the Administration processes the member's enrollment choice. Covered services shall be available on the date of the enroll-

ment change.

2. A member may change a member's enrollment choice:
   a. During a member's annual enrollment choice period,
   b. At any time from:
      i. IHS to a contractor as specified in subsection (A)(1) of this Section; or
      ii. A contractor to IHS~~,~~.
      ~~iii. IHS to a qualifying health center as specified in subsection (A)(1) of this Section~~,
      ~~iv. A qualifying health center to IHS,~~
      ~~v. A qualifying health center to a contractor.~~
   c. When a member is no longer a foster care child as specified in subsection (A)(3) of this Section.
3. Except for subsection (C)(2)(c) of this Section, the effective date of the new enrollment choice is the date the Administration processes the enrollment choice. The effective date of the enrollment change from CMDP to a Title XXI choice as specified in subsection (A)(1) of this Section, shall be the ~~1st~~ first of the following month.

D. Annual enrollment choice period. A member shall have the opportunity to change enrollment ~~within at least 12 months from the date of initial enrollment and then~~ no later than 12 months following the last time a member made an enrollment choice or had the opportunity to make an enrollment choice.

E. Health Insurance Portability and Accountability Act of 1996. As specified in A.R.S. § 36-2982, a Title XXI member who has been disenrolled shall be allowed to use enrollment in the Title XXI program as creditable coverage as defined in A.R.S. § 36-2984.

R9-31-307. Guaranteed Enrollment

A. Guaranteed Enrollment. A child who ~~has been~~ is determined eligible for Title XXI shall be guaranteed a one-time, 12-month period of continuous coverage unless a child:
1. Attains age 19,
2. Is no longer a resident of the state,
3. Is an inmate of a public institution,
~~4. Is enrolled with Title XIX,~~
~~5.~~4. Is determined to have been ineligible at the time of approval,
~~6.~~5. Obtains private or group health coverage,
~~7.~~6. Is adopted and the new household does not meet the qualifications of this program,
~~8.~~7. Is a patient in an institution for mental diseases,
~~9.~~8. Has ~~Whereabouts~~ whereabouts ~~is~~ that are unknown, or
~~10.~~9.~~A child's parent or legal guardian:~~ Has a head of household who:
   a. Does not pay cost sharing premium amount when premiums are required as specified in A.R.S. § 36-2982 and as specified in this Chapter,
   b. Voluntarily withdraws from the program, or
   c. Fails to cooperate in meeting the requirements of the program.

B. The 12-month guaranteed period shall begin with the month an applicant is initially enrolled.

R9-31-308. Changes and Redeterminations

A. Reporting Changes. A member or a member's parent or guardian shall report the following changes to the Administration:
1. Any ~~change~~ increase in income that will begin or continue into the following month,
2. Any change of address,
3. The addition or departure of a household member,
4. Any health coverage under private or group health insurance,
5. Employment of a member or a parent with a state agency, and
6. Incarceration of a member.

B. Verification. If required verification is needed and requested as a result of a change specified in subsection (A) of this Section to determine the impact on eligibility and is not received within 10 days, the Administration ~~may~~ shall send a notice to discontinue eligibility for a member unless a member is within the guaranteed eligibility period as specified in R9-31-307.

C. Redeterminations. If no change is reported, the Administration shall initiate redetermination no later than the end of the 12th month after the effective date of eligibility, or the completion of the most recent redetermination ~~application,~~ decision whichever is later.

D. Termination. If the Administration determines that a child no longer meets the eligibility criteria, or ~~a child, a parent, or a guardian~~ a head of household fails to respond or cooperate with the redetermination of eligibility, the Administration shall terminate coverage. ~~will be terminated.~~

R9-31-310. Notice Requirements

A. Applications. Upon completion of a determination of eligibility or ineligibility for any child in the household, the Administration shall issue a written notice to an individual who initiated the application. This notice shall include a statement of the intended action, an explanation of a person's hearing rights as specified in 9 A.A.C. 31, Article 8, and:
1. If approved, the notice shall contain the name and effective date of eligibility for each approved applicant;
2. If denied, the notice shall contain:
   a. The name of each ineligible applicant,
   b. The effective date of the denial,
   c. The reasons for ineligibility including appropriate income calculations and income standard when the reason for the denial is based on excess income,
   d. The legal authority supporting the reason for ineligibility, and
   e. ~~Where the references are physically located for review.~~ The resource or reference materials where the legal authority citations are found.

B. Terminations.
1. When the Administration proposes a termination of Title XXI eligibility, the Administration shall provide a member with:
   a. Advance notice at least 10 days before the effective date of the adverse action except as provided in subsection (B)(1)(b).
   b. Adequate notice no later than the date of adverse action when a member:
      i. Voluntarily withdraws and indicates an understanding of the results of the action,
      ii. Becomes an inmate of a public institution as specified in R9-31-303(I),
      iii. Dies and the Administration has verification of the death,
      iv. Has whereabouts that are unknown and the Administration's loss of contact is confirmed by returned mail from the post office with no forwarding address, or
      v. Is approved for Title XIX.
2. In addition to the requirements listed in subsection (A)(2), the termination notice shall include an explanation of a member's right to continued Title XXI coverage pending ~~appeal~~ a request for hearing as provided in 9 A.A.C. 31, Article 8 and 14. ~~A premium paying member has the right to continued Title XXI coverage pending an appeal if the member meets the requirements specified in this Chapter.~~

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-31-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions

A. A contractor or the ~~contractor's marketing representative~~ any person or entity acting as the contractor's marketing agent shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure Title XXI enrollment. A contractor may make ~~Title XXI~~ program applications available, but shall not assist with the completion of an application or ~~steer~~ suggest that an applicant ~~into a~~ enroll with particular contractor. Any marketing solicitation offering a benefit, good, or service, in excess of the covered services in 9 A.A.C. 31, Article 2 shall be deemed an inducement.

B. ~~A marketing representative~~ Any person or entity acting as the contractor's marketing agent shall not misrepresent itself, the contractor represented, or the ~~Title XXI~~ program, through false advertising, false statements, or in any other manner to induce a member of ~~another contracting entity~~ a current contractor to enroll ~~in the represented~~ with the prospective contractor. The Administration shall deem violations of this subsection to include, ~~but not be limited to,~~ false or misleading claims, inferences, or representations that:
1. A member ~~shall~~ will lose benefits under the ~~Title XXI~~ program or any other health or welfare benefits to which the member is legally entitled, if the member does not enroll ~~in~~ with the ~~represented~~ prospective contractor;
2. Marketing representatives are employees of the state or representatives of the Administration, a county, or any contractor other than the contractor with whom they are employed, or by whom they are reimbursed; and
3. The represented contractor is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the ~~health plan~~ contractor and the Administration.

C. ~~A marketing representative~~ Any person or entity acting as the contractor's marketing agent shall not engage in any marketing or pre-enrollment practice that discriminates against a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.

D. The Administration shall hold a contractor responsible for the performance of ~~any marketing representative~~ any person or entity acting as the contractor's marketing agent , subcontractor or agent, program, or process under its employ or direction and shall make the contractor subject to the contract sanctions in ~~this Chapter~~ 9 A.A.C. 31, Article 6.

R9-31-507. Member Record

As specified in A.R.S. § 36-2986, a contractor shall maintain a member service record that contains at least the following for each member:

1. Encounter data,
2. Grievances and ~~appeals~~ requests for hearing,
3. Any informal complaints, and
4. Service information.

R9-31-509. Transition and Coordination of Member Care

A. As specified in A.R.S. § 36-2986, the Administration shall coordinate and implement disenrollment and re-enrollment procedures ~~when~~ if a member's change of residency requires a change in contractor.

B. A contractor shall assist in the transition of members to and from other contractors.
1. Both the receiving and relinquishing contractor shall:
   a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. A contractor's policies and procedures regarding transition of members are subject to review and approval by the Administration;
   b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
   c. Develop policies and procedures ~~to be followed when~~ for transitioning members who have significant medical conditions, are receiving ongoing services, or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract~~;~~.
3. The relinquishing contractor shall forward medical records and other materials regarding the member's medical condition to the receiving contractor. The cost of reproducing and forwarding medical records and other materials shall be borne by the relinquishing contractor~~;~~.
4. Within the contract-specified timelines, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
   a. Information regarding the contractor's providers,
   b. Emergency numbers, and
   c. Instructions about how to obtain new services.

C. A contractor shall not use a county or ~~nonprovider~~ noncontracting provider health resource alternative that diminishes the contractor's contractual responsibility or accountability for providing the full scope of covered services. The Administration may sanction a contractor under 9 A.A.C.31, Article 6 for ~~Referrals~~ referrals made to other health agencies by ~~a~~ the contractor, primarily to reduce expenditures incurred by the contractor on behalf of its members~~;~~, ~~may result in the application of sanctions described in this Chapter.~~

D. A contractor may transfer a member as specified in A.R.S. § 36-2986, from a noncontracting provider to a contracting provider's facility ~~as soon as~~ if a transfer will not be harmful to the member's health as authorized by the member's primary care provider or the contractor's ~~Medical Director~~ medical director. A member's ~~plan~~ contractor shall pay the cost of transfer.

R9-31-511. Fraud or Abuse

As specified in A.R.S. §§ 36-2986 and 36-2992, a contractor, provider, or ~~nonprovider~~ noncontracting provider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.

R9-31-513. Discrimination Prohibition

A. A contractor, provider, ~~and~~ or ~~nonprovider~~ noncontracting provider shall not discriminate against a member: ~~because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability in accordance with~~
1. Under Title VI of the U.S. Civil Rights Act of 1964, 42 U.S.C. 2000d,
2. Because of:
   a. Marital status,
   b. Sexual preference,
   c. Age,
   d. Sex, or
   e. Behavioral disability, ~~and~~ or
3. ~~rules and regulations promulgated according to,~~ In violation of any other rule or regulation ~~or as otherwise~~ provided by law.

B. For the purpose of providing a covered service under contract according to A.R.S. Title 36, Ch. 29, discrimination includes~~, but is not limited to,~~ the following if done on the grounds ~~of the member's race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability:~~ subsection (A).
1. Denying or providing a member any covered service or availability of a facility;

2. Providing to a member any covered service that is different, or is provided in a different manner or at a different time from that provided to other ~~Title XXI~~ members under contract, other public or private members, or the public at large except when medically necessary;
3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service;
4. ~~restricting~~ Restricting a member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
~~4.~~5. Assigning to a member times or places for the provision of services that are different from those assigned to other ~~Title XXI~~ members ~~under contract~~.

~~B.~~C. A contractor shall take affirmative action to ensure that members are provided covered services ~~without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental disability,~~ without discrimination under Section (A) except where medically indicated.

R9-31-521. Program Compliance Audits

A. As specified in A.R.S. § 36-2986, the Administration shall conduct a program compliance audit of a contractor at least once every 12 months during the term of its contract with the contractor. Unless the Administration determines that advance notice will render a program compliance audit less useful, a contractor shall be notified ~~approximately~~ at least three weeks in advance of the date of an onsite program compliance audit. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit, either in conjunction with the program compliance audit or as part of an unannounced inspection program.

B. ~~A~~ The Administration's review team may perform any or all of the following procedures:
1. Conduct private interviews and group conferences with members, physicians, and other health professionals and members of ~~the~~ a contractor's administrative staff including, but not limited to, the contractor's principal management persons;
2. Examine records, books, reports, and papers of ~~the~~ a contractor and any management company, and all providers or subcontractors providing health care and other services to the ~~health plan~~ contractor. The examination may include, but not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the ~~health plan~~ contractor, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-31-1205. Scope of Behavioral Health Services

A. Inpatient behavioral health services. The following inpatient services shall be covered subject to the limitations and exclusions in this Article.
1. Inpatient behavioral health services provided in a Medicare (Title XVIII) certified hospital include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment. The behavioral health service shall be provided under the direction of a physician in:
   a. A general acute care hospital, or
   b. An inpatient psychiatric hospital.
2. Inpatient service limitations:
   a. Inpatient services, other than emergency services specified in this Section, ~~shall be~~ are prior authorized.
   b. Inpatient services ~~shall be~~ are reimbursed on a per diem basis and s~~hall be inclusive of~~ includes all services and room and board, except the following may bill independently for services: ~~and the services do not count toward the 30-day 30- visit annual limitation:~~
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified marriage and family therapist,
      vii. A certified professional counselor, or
      viii. A behavioral health medical practitioner under R9-31-112.
   c. ~~Title XXI funding for IMD inpatient services is available only to a member who is under 19 years of age. Title XXI funding shall not exceed 30 days inpatient care after an eligibility determination.~~ A member cannot be in an IMD at the time of application or at the time of redetermination.
   ~~d. Inpatient services are limited to a maximum of 30 days per contract year.~~

B. Level I ~~Residential Treatment Center Services~~ residential treatment center services. ~~The following Residential Treatment Center~~ Level I residential treatment center services ~~shall be~~ under 9 A.A.C. 20 Article 2 and Article 5 are covered subject to the limitations and exclusions in this Article~~.~~ and:

1. ~~Level I Residential Treatment Center services shall be~~ Are provided under the direction of a physician in a Level I ~~Residential~~ residential treatment center accredited by an AHCCCS approved accrediting body as specified in contract.
2. ~~Residential Treatment Center services include~~ Are room and board and treatment services for mental health and substance abuse conditions.
3. Residential ~~Treatment Center~~ treatment center service ~~limitations:~~ are limited as follows:
   a. Services ~~shall be~~ are prior authorized, except for emergency services as specified in this Section.
   b. Services ~~shall be~~ are reimbursed on a per diem basis and ~~shall be~~ are inclusive of all services, except the following may bill independently for services:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified marriage and family therapist,
      vii. A certified professional counselor, or
      viii. A behavioral health medical practitioner.
   c. ~~Title XXI funding for IMD inpatient services is available only to a member who is under 19 years of age.~~ An applicant or member cannot be in an IMD at the time of application or at the time of redetermination.
4. The following services may be billed independently if prescribed by a provider specified in ~~this Section~~ subsection (B)(3)(b)(i), (ii), (iii), and (viii):
   a. Laboratory,
   b. Radiology, and
   c. Psychotropic medication.

C. Level I ~~Sub-acute Facility Services~~ sub-acute facility services. ~~The following~~ Level I sub-acute facility services ~~shall be~~ under 9 A.A.C. 20, Article 2 and Article 5 are covered subject to the limitations and exclusions in this Article~~.~~ and:

1. ~~Level I sub-acute facility services shall be~~ Are provided under the direction of a physician in a Level I sub-acute facility accredited by an AHCCCS approved accrediting body as specified in contract.
2. ~~Level I sub-acute services include~~ Are room and board and treatment services for mental health and substance abuse conditions.
3. ~~Services shall be~~ Are reimbursed on a per diem basis and ~~shall be~~ are inclusive of all services, except the following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,
   g. A certified professional counselor, or
   h. A behavioral health medical practitioner.
4. ~~Title XXI funding for IMD inpatient services is available only to a member who is under 19 years of age.~~ An applicant or member cannot be in an IMD at the time of application or at the time of redetermination.
5. The following services may be billed independently if prescribed by a provider specified in ~~this Section:~~ subsection (C)(3)(a), (b), (c), and (h):
   a. Laboratory,
   b. Radiology, and
   c. Psychotropic medication.

D. ADHS licensed Level II ~~Behavioral Health Residential Services~~ behavioral health residential services. ~~The following~~ Level II ~~Behavioral Health Residential~~ behavioral health residential services ~~shall be~~ under 9 A.A.C. 20, Article 2 and Article 4 are covered subject to the limitations and exclusions in this Article~~.~~ and:

1. ~~Level II Behavioral Health services shall be~~ Are provided by a licensed Level II agency.
2. ~~Services shall be~~ Are inclusive of all covered services except room and board.
3. The following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,

g. A certified professional counselor, or
h. A behavioral health medical practitioner.

E. ADHS licensed Level III ~~Behavioral Health Residential Services~~ behavioral health residential services. ~~The following~~ Level III Behavioral Health Residential services ~~shall be~~ under 9 A.A.C. 20, Article 2 and Article 4 are covered subject to the limitations and exclusions in this Article~~.~~ and:

1. ~~Level III Behavioral Health services shall be~~ Are provided by a licensed Level III agency.
2. ~~Services shall be~~ Are inclusive of all covered services except room and board.
3. The following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,
   g. A certified professional counselor, or
   h. A behavioral health medical practitioner.

F. Partial care. ~~The following partial~~ Partial care services ~~shall be~~ are covered subject to the limitations and exclusions in this Article.

1. Partial care service ~~shall be~~ is ~~provided~~ rendered by an agency qualified to provide a regularly scheduled day program of individual member, group or family activities that are designed to improve the ability of the member to function in the community.
2. ~~Partial care services count toward the 30-day limitation during each contract year. Each full day of partial care, basic or intensive, counts as 1/2 day of inpatient care. Each 1/2 day of partial care, basic or intensive, counts as 1/4 day of inpatient care.~~
3.2. Partial care service exclusions. School attendance and educational hours ~~shall not be~~ are not included as a partial care service and ~~shall not be~~ are not billed concurrently with ~~these services~~ a partial care service.

G. Outpatient services. ~~The following outpatient~~ Outpatient services ~~shall be~~ are covered subject to the limitations and exclusions in this Article.

1. Outpatient services shall include the following:
   a. Screening provided by a behavioral health professional or a behavioral health technician;
   b. Initial behavioral health evaluation provided by a behavioral health professional;
   c. Ongoing behavioral health evaluation by a behavioral health professional or a behavioral health technician;
   d. Counseling including individual therapy, group, and family therapy provided by a behavioral health professional or a behavioral health technician;
   e. Behavior management services provided by qualified individuals or agencies as specified in contract; and
   f. Psychosocial rehabilitation services provided by qualified individuals or agencies as specified in contract.
2. Outpatient service limitations:
   a. The following practitioners may bill independently:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant as defined in this Article,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified professional counselor,
      vii. A certified marriage and family therapist,
      viii. A behavioral health medical practitioner,
      ix. A therapeutic foster parent under 6 A.A.C. 5, Article 58, and
      x. Other AHCCCS registered providers as specified in contract.
   b. ~~Other~~ A behavioral health ~~professionals~~ professional not specified in subsection (G)(2)(a) shall not bill independently unless ~~be~~ employed by, or contracted with, an AHCCCS-registered behavioral health agency.
   c. ~~The total number of all outpatient services shall not exceed a maximum of 30 visits during each contract year. Screening performed once every six months shall not count toward the 30-visit maximum.~~
   d. ~~Each outpatient service except group therapy or group counseling shall count as one visit. Each group therapy or group counseling service shall count as 1/2 a visit.~~

H. Behavioral health emergency services.

1. A RBHA shall ensure that behavioral health emergency services are provided by qualified personnel specified in R9-31-1206. The emergency services ~~shall be~~ are available 24 hours per day, seven days per week in the RBHA's service area in emergency situations ~~where~~ for a member who is a danger to self or others or is otherwise determined to be in

need of immediate unscheduled behavioral health services. Behavioral health emergency services ~~may be~~ are provided on either an inpatient or outpatient basis.

2. A contractor shall provide behavioral health emergency services on an inpatient basis not to exceed three days per emergency episode and 12 days per contract year, for a member not yet enrolled with a RBHA.
3. An inpatient emergency service provider shall verify the eligibility and enrollment of a member through the Administration to determine the need for notification to a contractor or a RBHA and to determine the party responsible for payment of services under Article 7 of this Chapter.
4. Behavioral health emergency service limitations:
   a. An emergency behavioral health service does not require prior authorization. The provider shall, however, comply with the notification requirements under R9-31-210.
   b. A behavioral health service for an ~~unrelated~~ condition unrelated to the behavioral health emergency service that requires diagnosis and treatment shall be prior authorized by a RBHA.
   c. Inpatient service limitations specified in subsection (A) of this Section shall apply to emergency services provided on an inpatient basis.
   ~~d. Emergency or crisis behavioral health services provided on an outpatient basis by a psychiatrist, a certified psychiatric nurse practitioner, a physician assistant, or a psychologist shall not count toward the outpatient service limitations specified in this Section.~~

I. Other behavioral health services. ~~The following services are covered but are not included in the visit limitations:~~
1. Case management as under R9-31-1201;
2. Laboratory and radiology services for behavioral health diagnosis and medication management;
3. Psychotropic medication and related medication;
4. ~~Medication monitoring~~ Monitoring, administration, and adjustment for psychotropic medication and related medications;
5. Respite care;
6. Therapeutic foster care; and
~~7. Personal assistance; and~~
~~8.~~7. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.

J. Transportation services. The Administration shall provide transportation services under A.A.C. R9-22-211.
~~1. Emergency transportation shall be covered for a behavioral health emergency specified in R9-31-211. Emergency transportation is limited to behavioral health emergencies.~~
~~2. Non-emergency transportation for a behavioral health service is excluded.~~

R9-31-1207. Standards for Payments

A. Payment to ADHS. ADHS shall receive a monthly capitation payment, based on the number of Title XXI members at the beginning of each month. ADHS administrative costs shall be incorporated into the capitation payment.

B. Claims submissions.
1. ADHS shall require all contracted service providers to submit clean claims no later than the time-frame specified in the ADHS contract with the Administration.
2. A claim for emergency inpatient services for a member not yet enrolled with an RBHA shall be submitted to a ~~health plan~~ contractor by a provider and shall comply with the time-frames and other applicable payment procedures in Article 7 of this Chapter.

C. Prior authorization. The Administration has the authority to deny ~~Payment~~ payment to a provider for services or items requiring prior authorization ~~may be denied~~ if prior authorization is not obtained from the Administration, ~~an~~ a RBHA, or a ~~health plan~~ contractor as specified in R9-31-705.

ARTICLE 14. PREMIUMS

R9-31-1403. Administration Requirements for Premium Payment

A. Administration requirements for premium paying members.
1. Prepayment of the initial premium is not required for initial enrollment in the program.
2. The monthly premium payment is due on the 15th day of the month of coverage.
3. A payment is considered received ~~when~~ on the date that the Administration receives it, as evidenced by the Administration's date stamp.
4. If the Administration does not receive the payment by the 15th day of the month, it is considered late.
5. ~~Payments~~ Except for payments made to continue benefits during a hearing, all payments shall first be applied to any debt owed. Any remaining amounts shall be applied to the next month's premium charge.
6. If payment for a month is not received in full by the last working day of the month in which the payment is due, the Administration shall include the following information with the premium billing statement:
   a. Past and current due amounts;
   b. Right to request a hardship exemption under R9-31-1404 including the required process for requesting the hardship exemption; and

c. Right to request review of payment record if the member believes the Administration to be in error.

~~6.~~7. ~~If payment for a month is not received in full by the 15th day of the following month, the~~ The Administration shall send a 10-day adverse action notice proposing termination to the head of household as specified in R9-31-310(B)~~.~~ if one or both of the following occur:

a. The head of household does not pay the past and current due amounts by the 15th of the month in which the Administration sends the notice,

b. The head of household submits a request for exemption of disenrollment requirement which that is denied.

~~7. If the Administration receives the late payment in full before the effective date of the termination, benefits will be continued, otherwise, services shall end on the effective date.~~

8. The Administration shall continue benefits and rescind the adverse action notice if one of the following occurs:

a. Approval of the hardship exemption under R9-31-1404 for both months,

b. Approval of the hardship exemption under R9-31-1404 for one month and receipt of payment for one month, or

c. Receipt of the late payment in full before the effective date of the termination.

9. The Administration shall terminate the benefits on the effective date if no action as described in subsection (A)(8) occurs.

B. Premium submission by member.

1. A member shall pay the premium in the form of a:
   a. Cashier's check,
   b. Personal check, or
   c. Money order.
2. The Administration ~~may~~ shall decline to accept a personal check when:
   a. The member has previously paid with a personal check that was returned to the Administration because of insufficient funds, or
   b. The check is to pay for continued services during the grievance and ~~appeal~~ request for hearing process as specified in ~~R9-31-1405~~ R9-31-1406.
3. A member may pay premiums in advance.
4. When a member pays for more than one month at a time and is subsequently determined ineligible for the ~~KidsCare~~ program, the Administration shall reimburse the member for any months of coverage not used except as specified in ~~R9-31-1405~~ R9-31-1406.

R9-31-1404. Hardship Exemption

A. Definitions. The following definitions apply to this Section:

1. "Major expense" means the expense is more than 10 percent of the household's countable income under R9-31-304.
2. "Medically necessary" has the same meaning as defined in A.A.C. R9-22-101.

B. Hardship exemption. The Administration shall grant a hardship exemption from the disenrollment requirements under A.R.S. § 36-2982 and R9-31-1403 for a household who:

1. Is no longer able to pay the premium due to one of the hardship criteria in subsection (C), and
2. Submits a written request for a hardship exemption and provides all necessary written information at the time of request.

C. Hardship criteria. Hardship criteria are:

1. Medically necessary expenses or health insurance premiums that:
   a. Are not covered under Medicaid or other insurance, and
   b. Exceed 10 percent of the household's countable income under R9-31-304;
2. Unanticipated major expense, related to the maintaining a residence for the household or transportation for work;
3. A combination of medically necessary under subsection (C)(1) and unanticipated major expenses under subsection (C)(2) that exceed 10 percent of the household's countable income under R9-31-304; or
4. Death of a household member.

D. Written hardship exemption request. The Administration shall not consider a hardship exemption unless the Administration receives the written request and information under R-31-1404(C) by the 10th day of the month in which the household receives the billing statement containing the current and past due premium notice.

E. Notification. The Administration shall notify the head of household of the approval or denial of the request for exemption and discontinuance under R9-31-310, no later than 10 days from the date the Administration received the request.

F. Request for hearing. The head of household may request a hearing concerning the termination and denial of exemption under R9-31-802.

~~R9-31-1404.~~R9-31-1405. Termination for Failure to Pay; Bad Debt

A. Missed payments. If a member's coverage is terminated because of two consecutive months with unpaid premiums, the member shall not be reenrolled until all premiums are paid.

B. Termination and reenrollment. A member who is terminated from the program for failure to pay may reapply and be reenrolled as soon as full payment is made~~. There is no limit to~~ regardless of the number of times a member ~~shall be~~ is termi-

nated from the program for failure to pay and ~~be~~ is reenrolled based on full payment. ~~The Administration shall not impose an extended penalty for failure to pay.~~

C. Debt. When the member is terminated from the program for failure to pay the required premiums, payment of the unpaid amount is the responsibility of the head of the household. If the household separates at a later time, the debt remains the responsibility of the original head of the household. ~~Nobody~~ The Administration shall not reenroll any member in the household ~~shall be reenrolled in the program~~ until all premiums are paid in full.

~~R9-31-1405.~~R9-31-1406. Premiums during the Grievance and ~~Appeal~~ Request for Hearing Process

A. Process. Except as otherwise specified in this Chapter, all Title XXI grievances and ~~appeals~~ requests for hearing relating to an adverse action~~, decision, or policy~~ shall be processed according to the standards set by the Administration in 9 A.A.C. 31, Article 8, and as specified in contract with contractors and provider agreements.

B. ~~Filing an appeal~~ Continuance Benefits. A member filing ~~an appeal~~ a request for hearing because of a discontinuance of eligibility before the effective date of the discontinuance ~~and who requests to continue~~ service~~s~~ d~~uring the appeal process will pay 3 full months of premiums in advance~~ who pays a one month premium in advance to the Administration no later than the effective date of the adverse action shall continue to receive benefits. A member shall continue to pay the premium by the 15th of each month during the request for hearing process in order to continue benefits.

C. Non-Continuance of Benefits. A member who fails to pay ~~3 full months of~~ the premiums ~~in advance~~ may still request a hearing as specified in 9 A.A.C. 31, Article 8, but ~~services~~ benefits ~~shall not be~~ are not continued pending the ~~appeal~~ hearing process.

~~C.~~D. Payment for continued ~~services~~ benefits pending ~~appeal~~ hearing. A member paying a premium to continue benefits during ~~an appeal~~ a hearing process shall pay ~~3 months of premiums~~ each month by:

1. Certified check, or
2. Money order.

~~D.~~E. Non-refundable premium. The Administration shall not refund any portion of the ~~advance~~ premiums paid.

1. If a member's appeal is denied, any remaining ~~advance~~ premium paid shall be applied toward the administrative cost to the system.
2. If a member's appeal is upheld, any remaining ~~advance~~ premium paid shall be applied to the next month's premium charge.

~~R9-31-1406.~~R9-31-1407. Newborns

Newborns. ~~All deemed~~ A member's ~~newborns shall be~~ newborn is enrolled immediately upon the Administration's receiving notification of the child's birth. Upon enrollment, the household's premium ~~may be~~ is redetermined.

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1601. General Requirements

~~A.~~ ~~R9-31-1601 through R9-31-1624 apply to the acute care services provided to an enrolled member by IHS, a Tribal Facility, or a referral provider. R9-31-1618 through R9-31-1622 and R9-31-1625 apply to behavioral health services provided by the IHS, a Tribal Facility, RBHA or TRBHA.~~

~~B.~~ ~~As specified in A.R.S. § 36-2982, the Administration shall administer the program subject to the limitations on funding specified in A.R.S. § 36-2985.~~

~~C.~~ ~~As specified in A.R.S. § 36-2986, the Director has full operational authority to adopt rules or to use the appropriate rules adopted for this Article.~~

~~D.~~A. A Native American who is ~~eligible for Title XXI~~ a member may receive:

1. ~~covered~~ Covered acute care services specified in this ~~Article~~ Chapter from:
   ~~1.~~a. An IHS ~~Area Office~~ area office ~~as specified in~~ under A.R.S. § 36-2982 ~~which~~ that has a signed IGA with the Administration,
   ~~2.~~b. A Tribal Facility ~~as specified in~~ under A.R.S. § 36-2982, or
   ~~3.~~c. A contractor ~~which includes a health plan or a qualifying plan as defined in A.R.S. § 36-2981, or~~ under A.R.S. § 36-2901.
~~4. A qualifying health center as specified in A.R.S. § 36-2907.06.~~
2. Covered behavioral health care services as specified in this Chapter from:
   a. An IHS area office under A.R.S. § 36-2982 that has a signed IGA with the Administration,
   b. A Tribal Facility under A.R.S. § 36-2982, or
   c. A RBHA or TRBHA.

~~E.~~B. ~~The~~ In providing covered services to a member, IHS and a Tribal Facility shall comply with:

1. Federal and state law;
2. The IGA, if applicable; and
3. ~~The appropriate rules as specified in this Chapter.~~ This Chapter as applicable.

~~F.~~**C.** An individual or an entity that provides covered services for the IHS or a Tribal Facility shall be ~~a~~ an AHCCCS registered provider~~. who meets the appropriate certification standards established by the Administration. A provider shall be responsible for:~~
~~1. Supervising, coordinating, and providing initial and primary care to the member;~~
~~2. Initiating referrals for specialty care;~~
~~3. Maintaining continuity of member care; and~~
~~4. Maintaining an individual medical record for each assigned member.~~

~~G.~~**D.** The IHS and a Tribal Facility under 42 CFR 431.110 shall meet state requirements as a Medicaid provider. ~~shall maintain medical records that:~~ Medical records shall:
1. Conform to ~~professional medical standards and practices~~ 9 A.A.C. Chapter 20 for documentation of medical, diagnostic and treatment data;
2. Include a detailed record of:
   a. All medically necessary services provided to a member by the IHS or a Tribal Facility,
   b. All emergency services provided by a provider or a ~~nonprovider~~ noncontracting provider for a member enrolled with the IHS or receiving services from a Tribal Facility, ~~and~~
   c. All covered services provided through a referral to a facility or provider outside the IHS or Tribal facility network, and
3. Facilitate follow-up treatment.

~~H.~~**E.** As specified in A.R.S. §§ 36-2986 and 36-2992, the IHS or a Tribal Facility shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.

R9-31-1602. General Requirements for Scope of Services

A. In addition to the requirements and the limitations specified in this Chapter, the following general requirements apply:
1. ~~As specified in~~ under A.R.S. § 36-2989 ~~and R9-31-1625~~, covered services provided to a member shall be medically necessary and provided by, or under the direction of, the IHS, a Tribal Facility, a provider, or a dentist. Specialist services ~~shall be~~ are provided under referral from the IHS or a Tribal Facility provider.
~~2. If the IHS cannot provide a covered service due to the circumstances delineated in the signed Settlement Agreement CV-86-1105-PHX-RGS, a member shall be referred to a non-IHS provider or a non-IHS facility for the service and a referral form shall be completed and referred to the Administration based on procedures established by the Administration.~~
2. If IHS cannot provide a covered service due to in the appropriation of funds by Congress, the obligation to allocate IHS program resources nationwide, or a fundamental shift in the manner of providing health services to Native Americans on a national basis then a member shall be referred to a non IHS provider or a non IHS facility for the service.
~~3. Experimental services as determined by the Director, or services provided primarily for the purpose of research, shall not be covered;~~
~~4. Services or items, if furnished gratuitously, are not covered and payment shall be denied;~~
~~5. Personal care items are not covered and payment shall be denied; and~~
~~6. Services shall not be covered if provided to:~~
   ~~a. An inmate of a public institution,~~
   ~~b. A person who is a resident of an institution for the treatment of tuberculosis,~~
   ~~c. A person who is in an institution for the treatment of mental diseases at the time of application or at the time of redetermination, or~~
   ~~d. A person prior to the date of eligibility.~~

~~B. Services shall be provided by AHCCCS registered personnel or facilities which are appropriately licensed or certified to provide the services.~~

~~C. Payment for services or items requiring prior authorization as defined in this Article may be denied if prior authorization from the Administration is not obtained. Emergency services do not require prior authorization.~~
~~1. Services for unrelated conditions, requiring additional diagnostic and treatment procedures, require additional prior authorization.~~
~~2. Written documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.~~

~~D.~~**B.** As specified in A.R.S. § 36-2989, covered services rendered to a member ~~shall be~~ are provided within the service area of the IHS or a Tribal Facility except when:
1. An IHS or a Tribal Facility refers a member out of the area for medical specialty care or behavioral health services,
2. A covered service that is medically necessary for a member is not available within the service area, or
3. A member is placed in an NF located out of the service area.

~~E. If a member requests the provision of a service that is not covered by the program or not authorized by the IHS or a Tribal Facility, the service may be rendered to a member by an AHCCCS-registered service provider under the following conditions:~~

~~1. A document lists the requested services and the itemized cost of each is prepared by a provider or a nonprovider~~ non-contracting provider ~~and provided to a member, and~~

~~2. The signature of a member is obtained in advance of service provision indicating that the services have been explained to a member and that a member accepts responsibility for payment.~~

C. If a member requests the provision of service that is not covered or not authorized by the IHS or Tribal Facility, an AHCCCS registered provider may provide the service under the following conditions:

1. IHS or a Tribal Facility shall prepare and provide the member with a document that lists the requested services and the estimated cost of each service; and
2. The member signs a document prior to the provision of services indicating that the member understands the services and accepts the responsibility for payment.

~~F.~~**D.** Noncovered services provided to a member by the IHS, a Tribal Facility or under referral may be paid by the IHS or a Tribal Facility, but not with Title XXI funds.

R9-31-1610. Transportation Services

~~**A.** Emergency ambulance services.~~

~~1. As specified in A.R.S. § 36-2989, emergency ambulance transportation services shall be a covered service for a member. Payment shall be limited to the cost of transporting a member in a ground or air ambulance:~~

~~a. To the nearest appropriate provider or medical facility capable of meeting a member's medical needs, and~~

~~b. When no other means of transportation is both appropriate and available.~~

~~2. A ground or an air ambulance transport that originates in response to a 9-1-1 call or other emergency response system shall be reimbursed by the Administration for a member if the medical condition at the time of transport justified a medically necessary ambulance transport. No prior authorization is required for reimbursement of these transports.~~

~~3. Determination of whether transport is medically necessary shall be based upon the medical condition of a member at the time of transport.~~

~~4. Notification to the Administration of emergency transportation provided is not required but a provider shall submit documentation with the claim which justifies the service.~~

~~**B.** Air ambulance services shall be covered only if:~~

~~1. The air ambulance transport is initiated upon the request of an emergency response unit, a law enforcement official, a hospital, a clinic medical staff member, the IHS or a Tribal Facility provider, a physician, or a practitioner;~~

~~2. The point of pickup is inaccessible by ground ambulance, or great distances, or other obstacles are involved in getting emergency services to a member or transporting a member to the nearest hospital or other provider with appropriate facilities; and~~

~~3. The medical condition of a member requires timely ambulance service and ground ambulance service will not suffice.~~

~~**C.** Medically necessary member transfers provided by an emergency air or a ground transportation provider may be covered when a member receiving inpatient services requires transport to another level of care or requires round trip transport to another facility to obtain necessary specialized diagnostic treatment services if:~~

~~1. A member's condition is such that the use of any other method of transportation would be harmful to a member's health, and~~

~~2. Services are not available in the facility where a member is a patient.~~

~~**D.** Meals, lodging and escort services.~~

~~1. Expenses for meals and lodging for a member while en route to, or returning from, an approved and prior authorized health care service site out of a member's service area shall be a Title XXI covered service.~~

~~2. Expenses of an escort, who may be a family household member accompanying a member out of a member's service area shall be covered if the services of an escort are ordered in writing by an IHS or a Tribal Facility provider, an attending physician or a practitioner.~~

~~3. Meals, lodging and escort services provided by a provider shall be prior authorized by the Administration.~~

~~**E.** Limitations.~~

~~1. Expenses shall be allowed only when a member requires a covered service that is not available in the service area;~~

~~2. If a member is admitted to an inpatient facility, expenses for an escort shall be covered only when accompanying a member en route to, and returning from, the inpatient facility; and~~

~~3. A salary for an escort shall be covered if an escort is not a part of a member's family household.~~

~~**F.** Non-emergency transportation services are not covered as specified in A.R.S. § 36-2989.~~

The Administration shall provide transportation services under A.A.C. R9-22-211.

R9-31-1618. Claims

A. Claims submission to the Administration.

1. The IHS, a Tribal Facility, a TRBHA, or a provider under referral shall ensure that a claim for covered services provided to a member is initially received by the Administration not later than six months from the date of service. The Administration shall deny a claim not received within the six month period from the date of service. If a claim meets

the six month limitation, the IHS, a Tribal Facility, a TRBHA, or a provider under referral shall file a clean claim ~~which~~ that is received by the Administration not later than 12 months from the date of service.

2. The six and twelve-month deadlines for an inpatient hospital claim begin on the date of discharge for each claim.

B. Claims processing.

1. If a claim contains erroneous or conflicting information, exceeds parameters, fails to process correctly, does not match the Administration's files, or requires manual review to be resolved, the Administration shall report the claim to a provider with a remittance ~~advice~~ explanation.
2. The Administration shall process a hospital claim in accordance with A.A.C. R9-22-712.

C. Overpayments for Title XXI services. An IHS or a Tribal Facility provider, a ~~nonprovider~~ noncontracting provider, or a Tribal Facility, shall notify the Administration if ~~a Title XXI~~ an overpayment is made. The Administration shall recoup an overpayment from a future claim cycle, or, at the discretion of the Director, require the IHS or a Tribal Facility provider or a ~~nonprovider~~ noncontracting provider, to return the incorrect payment to the Administration.

R9-31-1622. The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care

A. ~~Liability to the Administration for an emergency medical condition of a member who is provided care outside the IHS or a Tribal Facility's service area shall be is subject to reimbursement only until a member's condition is stabilized and a member is transferable, or until a member is discharged following stabilization subject to the requirements of A.R.S. § 36-2989.~~

Expenses for an emergency or acute medical health condition of a member are reimbursed only until the member's condition is stabilized and the member is transferable, or until the member is discharged following stabilization subject to the requirements of this Chapter and A.R.S. § 36-2989. This Section only applies to those noncontracting hospitals outside the IHS or Tribal Facility network.

B. Subject to subsection (A), if a member cannot be transferred following stabilization to the IHS or a Tribal Facility, the Administration shall pay for all appropriately documented, prior authorized, and medically necessary treatment provided to a member before the ~~date of discharge~~ discharge date or transfer ~~according to payment standards in~~ under R9-31-705.

C. If a member refuses transfer from a ~~nonprovider~~ noncontracting provider or a noncontracting hospital to the IHS or a Tribal Facility, the Administration ~~shall not be~~ is not liable for any costs incurred after the date of refusal if:

1. After consultation with a member's IHS or a Tribal Facility, a member continues to refuse the transfer; and
2. A member ~~has been~~ is provided and signs a written statement, before the date ~~of transfer of liability,~~ the member is liable for payment informing a member of the medical and financial consequences of refusing to transfer. If a member refuses to sign a written statement, a statement signed by ~~2~~ two witnesses indicating that ~~a~~ the member was informed may be substituted.

R9-31-1625. Behavioral Health Services

A. The IHS, ~~a contractor,~~ a TRBHA, a RBHA or a Tribal Facility may provide any or all of the behavioral health services specified in 9 A.A.C. 31, Article 12, subject to the limitations and specifications stated in 9 A.A.C. 31, Article 12, to a Native American who is ~~eligible for Title XXI services~~ a member.

~~**B.** It is the responsibility of the IHS, a Tribal Facility, a contractor, a TRBHA or a RBHA to monitor the limitations and specifications prescribed in 9 A.A.C. 31, Article 12. Services provided in excess of the limitations and specifications prescribed in 9 A.A.C. 31, Article 12 shall not be reimbursed by the Administration.~~

~~**C.**~~**B.** The IHS, a Tribal Facility, a contractor, a TRBHA or a RBHA shall cooperate as specified in contract, IGA, or this Chapter when the transition from one entity to another becomes necessary. ~~For a Title XXI member, this transition shall include tracking and reporting of services used by a member toward the annual limitations prior to the transfer of care.~~

~~**D.**~~**C.** The IHS and a Tribal Facility shall be considered a provider for the provision of behavioral health services and shall be subject to the requirements of:

1. A TRBHA if one is operating in a service area, or
2. A RBHA in a service area that does not have a TRBHA or a contractor for a Native American member with respect to prior authorization and service authorizations.

~~**E.**~~**D.** If either the IHS or a Tribal Facility cannot provide a nonemergency inpatient or an outpatient behavioral health service, the IHS or a Tribal Facility shall refer the member to a RBHA or a TRBHA.

~~**F.**~~**E.** ~~Behavioral health emergency and crisis stabilization services shall be handled as follows:~~ If a member is enrolled with a contractor and is not enrolled with a TRBHA or a RBHA, the contractor is responsible for the provision of emergency behavioral health services for up to three days per admission, not to exceed 12 days per contract year, and shall refer a member to a TRBHA or a RBHA for continued service authorization and any needed additional services.

~~1. If a member is enrolled with the IHS or a contractor and is not enrolled with a TRBHA or a RBHA, the IHS or a contractor is responsible for the provision of emergency behavioral health services for up to 3 days per admission, not to exceed 12 days per contract year, and shall refer a member to a TRBHA or RBHA.~~

~~2. Inpatient service limitations shall apply to emergency or crisis stabilization services provided on an inpatient basis.~~

~~3. Emergency or crisis intervention services provided on an outpatient basis by a psychiatrist, a certified psychiatric nurse practitioner, a psychologist, or a qualified facility shall not count towards the outpatient service limitation.~~

~~**G.F.** Prior~~ The provider shall obtain prior authorization ~~must be obtained~~ for all inpatient hospitalizations and partial care services as authorized in R9-31-1202 and R9-31-1203.

~~**H.G.**~~A provider shall comply with the requirements specified in subsections (B)~~,~~ and (C)~~,~~. ~~and (D)~~ ~~or~~ If a provider fails to comply, payment ~~may be~~ is denied, or if paid, ~~may be~~ is recouped by the Administration.

~~**I.H.**~~ A behavioral health service provided by the IHS or a Tribal Facility shall be reimbursed as specified in R9-31-1616.

NOTICE OF FINAL RULEMAKING

TITLE 14. PUBLIC SERVICE CORPORATIONS; CORPORATIONS AND ASSOCIATIONS; SECURITIES REGULATION

CHAPTER 4. CORPORATION COMMISSION - SECURITIES

PREAMBLE

1. Section Affected **Rulemaking Action**
R14-4-148 New Section

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rule is implementing (specific):

Authorizing statutes: A.R.S. §§ 44-1821, and 44-1845

Implementing statutes: A.R.S. §§ 44-1844, 44-1941, and 44-1945

Constitutional authority: Arizona Constitution Article XV §§ 4, 6, and 13

3. The effective date of the rule:

December 6, 2001

4. A list of all previous notices appearing in the Register addressing the final rule:

Notice of Rulemaking Docket Opening: 6 A.A.R. 1746, May 12, 2000

Notice of Proposed Rulemaking: 6 A.A.R. 3169, August 25, 2000

Notice of Supplemental Proposed Rulemaking: 7 A.A.R. 1002, May 2, 2001

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Sharleen A. Day, Associate General Counsel

Address: Arizona Corporation Commission, Securities Division
1300 W. Washington, Third Floor
Phoenix, AZ 85007-2996

Phone: (602) 542-4242

Fax Number: (602) 594-7421

6. An explanation of the rule, including the agency's reasons for initiating the rule:

The Arizona Corporation Commission (Commission) adds new Section R14-4-148 in order to: (i) provide for an exemption for transactions effected by Canadian dealers and their salesmen in certain Canadian accounts; (ii) detail the requirements for the grant and maintenance of the exemption; (iii) enumerate the application and renewal requirements for the exemption; and (iv) detail the extent of the activity permitted in Arizona under the exemption. A brief description of the section covered by this rulemaking follows:

To effect transactions under this section, the Canadian dealers must be domiciled in Canada, have no office or other physical presence in the United States, and not be an office or a branch of a dealer domiciled in the United States.

The Canadian dealer and its salesmen may only effect transactions in securities with or for, or induce or attempt to induce the purchase or sale of any security by (i) a person from Canada who temporarily resides in or is present in Arizona and with whom the Canadian dealer had a bona fide dealer-client relationship before the person entered the United States, or (ii) a person who resides in or is temporarily present in Arizona and whose transactions are in a self-directed tax advantaged retirement plan in Canada of which the person is the holder or contributor.

To effect transactions under this section, a dealer shall (i) be a member of a Canadian SRO, stock exchange or Bureau des Service Financiers, and (ii) maintain in good standing provincial or territorial registration and membership in a Canadian SRO, stock exchange or Bureau des Service Financiers. Salesmen may effect transactions under this section to the same extent as their dealer provided they are registered and in good standing in the jurisdiction from which they are effecting transactions, has not been convicted of a felony or misdemeanor of which fraud is an essential element, or is currently enjoined from engaging in any conduct in connection with the purchase and sale of securities.

Prior to effecting transactions under this section, a dealer must file (i) a copy of its last registration or renewal application filed in the jurisdiction in which the dealer has its principal office, (ii) a consent to service of process; (iii) the fee required under A.R.S. § 44-1861(G); (iv) written evidence that the dealer's membership in the Canadian SRO, stock exchange, or the Bureau des Services Financiers is in good standing; and (v) a copy of each salesman's registration or renewal application filed in the jurisdiction in which the salesman is registered and resident, and a consent to service of process for each salesman.

Each notice filed under this Section shall be effective on the date received by the Commission and expire on December 31.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The summary of the economic, small business, and consumer impact:

The economic, small business, and consumer impact statement for Section R14-4-148 ("rule 148") analyzes the costs, savings, and benefits that accrue to the Commission, the office of the attorney general, the regulated public, and the general public. With the adoption of rule 148, the impact on established Commission procedures, Commission staff time, and other administrative costs is minimal. The estimated additional cost to the office of the attorney general is minimal. The benefits provided by rule 148 are nonquantifiable. Rule 148 should benefit the Commission's relations with the regulated public because the grant of an exemption will permit Canadian dealers and salesmen to manage and transact business in the accounts of their clients while those clients are in Arizona. The public will benefit from the continuation of certain standards for dealers and salesmen and will benefit from the convenience of effecting transactions in their accounts while in Arizona. The Commission anticipates that the rulemaking will not significantly increase monitoring, recordkeeping, or reporting burdens on businesses or persons. The costs of implementation or enforcement are only marginally increased. Please provide comment regarding the accuracy of this summary to the individual named in item #5 above.

9. A description of the changes between the proposed rule, including supplemental notices, and the final rule (if applicable):

The Commission originally proposed a limited registration for Canadian dealers and their salesmen effecting certain transactions in Arizona. Based upon information obtained during the public comment period, the Commission amended its proposal in the Notice of Supplemental Proposed Rulemaking to propose an exemption for Canadian dealers and their salesmen effecting certain transactions in Arizona. In response to written comments on the amended proposal, the Commission has proposed changes to the text of one section, which is not substantially different from the proposed rule reflected in the Notice of Supplemental Proposed Rulemaking. That change is set forth below and has been incorporated into the rule attached to this Notice.

R14-4-148(B): The dealer must be domiciled in Canada, have no office or other physical presence in the United States, and not be an office ~~of,~~ or a branch of~~, or a natural person associated with~~ a dealer domiciled in the United States.

10. A summary of the principal comments and the agency response to them:

The agency received four comment letters following the Notice of Supplemental Proposed Rulemaking from the following organizations: the Investment Dealers Association of Canada (the "IDA"), Dorsey & Whitney, a follow up letter from Dorsey & Whitney, and Edward Jones. The letter from the IDA expressed general support with no substantive comments. Comments from the other organizations addressed the following:

R14-4-148(B) limits the availability of the exemption to those entities domiciled in Canada, with no office or other physical presence in the United States. That limitation excluded offices, branches or natural persons associated with a dealer domiciled in the United States from using the exemption. Edward Jones and Dorsey & Whitney recommended the language in section B be amended to clarify that the exemption is available to Canadian salesmen of a Canadian subsidiary of a United States dealer as well as Canadian sister entities or Canadian subsidiaries of United States dealers. Edward Jones recommended the Commission delete the phrase "or a natural person associated with" in that section. Because a natural person located in the United States who is associated with a United States dealer would constitute a "physical presence" in the United States, the Commission considers the subject language to be redundant and revised the rule in accordance with the recommendation.

R14-4-148(E) provides for automatic disqualification from use of the exemption for certain individuals and entities that have poor disciplinary histories. Dorsey & Whitney recommended the Commission amend the language of the disqualifying provision in rule 148(E)(2) to eliminate the language "involving fraud, deceit, racketeering or consumer protection laws" and replace it with a requirement for a "finding of fraud or deceit or a finding of a violation of racketeering or consumer protection laws." The Commission did not make the recommended change because the subject language in rule 148(E) is identical to numerous other disqualifying provisions in the Securities Act and the Arizona Administrative Code and was intended to be subject to the same application and interpretation as those provisions.

R14-4-148(F) enumerates the filing requirements for dealers and salesmen effecting transactions under the exemption. Dorsey & Whitney recommended the Commission eliminate the requirement for a notice filing for all salesmen conducting business in Arizona under rule 148(F)(5) because Canadian dealers must employ salesmen that are appro-

priately registered and in good standing in the Canadian jurisdiction from which they are effecting transactions. Dorsey & Whitney contended that, in the absence of substantive regulation, the notice filing would impose significant costs to the dealers while adding little to investor protection. The Commission imposed an annual notice filing in order to ensure the Commission has current information regarding the entities and persons effecting securities transactions in Arizona by which to monitor compliance with rule 148 and to provide assistance to any investor seeking it from the Commission. Because the Commission retains full jurisdiction over all activities that fall outside of rule 148 as well as jurisdiction over all activities involving fraud, the Commission considered the information sought in the annual notice important and did not make the recommended change.

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

12. Incorporations by reference and their location in the rule:

Not applicable

13. Whether the rule was previously adopted as an emergency rule and, if so, whether the text was changed between adoption as an emergency rule and the adoption of the final rule.

Not applicable

14. The full text of the rule follows:

TITLE 14. PUBLIC SERVICE CORPORATIONS; CORPORATIONS AND ASSOCIATIONS; SECURITIES REGULATION

CHAPTER 4. CORPORATION COMMISSION - SECURITIES

ARTICLE 1. IN GENERAL RELATING TO THE ARIZONA SECURITIES ACT

Section

ARTICLE 1. IN GENERAL RELATING TO THE ARIZONA SECURITIES ACT

R14-4-148. Transactions Effected by Canadian Dealers and Salesmen

A. A transaction effected by or through a Canadian dealer or its salesmen is added to the class of transactions exempt under A.R.S. § 44-1844, provided the transaction is conducted in accordance with the terms of this Section.

B. The dealer must be domiciled in Canada, have no office or other physical presence in the United States, and not be an office or branch of a dealer domiciled in the United States.

C. The dealer and its salesmen may only effect transactions in securities with or for, or induce or attempt to induce the purchase or sale of any security by:

1. An individual from Canada who temporarily resides in or is temporarily present in this state and with whom the Canadian dealer had a bona fide dealer-client relationship before the individual entered the United States; or
2. An individual present in this state whose transactions are in a Canadian self-directed tax-advantaged retirement account of which the individual is the holder or contributor.

D. To effect transactions under this Section, a dealer shall:

1. Comply with the requirements of subsection (F).
2. Be registered with or a member of a Canadian SRO, stock exchange, or the Bureau des Services Financiers and maintain that registration or membership in good standing.
3. Disclose to its clients in this state that the dealer and its salesmen are not subject to the full regulatory requirements of the Arizona Securities Act.

E. An exemption under this Section shall not be available to a dealer or salesman if the dealer or salesman:

1. Has been convicted within ten years of the date of filing of the notice under this Section of a felony or misdemeanor of which fraud is an essential element, or a felony or misdemeanor involving the purchase or sale of securities or arising out of the conduct of the business as a dealer or salesman.
2. Is subject to an order, judgment, or decree issued by a court of competent jurisdiction, SRO, or administrative tribunal entered within 10 years preceding the filing of the notice under this Section enjoining or restraining the dealer or salesman from engaging in or continuing any conduct or practice in connection with the sale or purchase of securities or involving fraud, deceit, racketeering or consumer protection laws.

F. Prior to a dealer or salesman effecting a transaction under this Section, a dealer shall file with the Division a notice that contains the following:

1. A copy of the last registration or renewal application filed in the jurisdiction in which the dealer has its principal office, with all amendments since that filing.
2. A consent to service of process pursuant to A.R.S. § 44-1862.

3. The fee required under A.R.S. § 44-1861(G).
4. Written evidence that the dealer's membership in a Canadian SRO, stock exchange, or the Bureau des Services Financiers is in good standing.
5. For each salesman effecting transactions in Arizona, the dealer shall file
   a. A copy of the last registration or renewal application filed in the jurisdiction in which the salesman is registered and resident, with all amendments since that filing.
   b. A consent to service of process.
   c. Written evidence that the salesman is registered and in good standing in the jurisdiction from which he or she is effecting a transaction into this state.

G. A notice filed under this Section is effective on the date received by the Commission and expires on December 31.